

**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue Date: 01 February 2007**

**Case No.: 2005-LHC-1985**

**OWCP No.: 07-166349**

**IN THE MATTER OF**

**J. J.**

Claimant

**vs.**

**PRODUCTION MANAGEMENT CORPORATION,**  
Employer

**and**

**ACE AMERICAN INSURANCE COMPANY,**  
Carrier

**APPEARANCES:**

**H. EDWARD SHERMAN, ESQ.,**  
On Behalf of the Claimant

**KATHLEEN K. CHARVET, ESQ.,**  
**ADAM C. McNEIL, ESQ.,**  
On Behalf of the Employer

**BEFORE: PATRICK M. ROSENOW**  
Administrative Law Judge

**DECISION AND ORDER**

**PROCEDURAL STATUS**

This case arises from a claim for benefits under the Longshore Harbor Workers' Compensation Act (the Act),<sup>1</sup> brought by J.J. (Claimant) against Production Management Corporation (Employer) and Ace American Insurance Company (Carrier).<sup>2</sup>

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<sup>1</sup> 33 U.S.C. §901 *et seq.*

<sup>2</sup> For simplicity both Employer and Carrier are collectively referred to herein as Employer.

The matter was referred to the Office of Administrative Law Judges for a formal hearing. Both parties were represented by counsel. On 4-5 Apr 06, a hearing was held at which the parties were afforded a full opportunity to call and cross-examine witnesses, offer exhibits, make arguments, and submit post-hearing briefs.

My decision is based upon the entire record, which consists of the following:<sup>3</sup>

Witness Testimony of

Claimant  
Bernard Manale  
Ralph Katz  
Octave Jackson  
Kevin Bellow

John Gudan  
Claimant's girlfriend  
Troy Hux  
Donny Faust  
Michelle Brookman

Exhibits<sup>4</sup>

Claimant's Exhibits (CX) 1-39  
Employer's Exhibits (EX) 1-47

My findings and conclusions are based upon the stipulations of counsel, the evidence introduced, my observations of the demeanor of the witnesses, and the arguments presented.

**STIPULATIONS<sup>5</sup>**

1. If the injury took place as Claimant alleged:
  - a. There is jurisdiction and coverage under the Act.
  - b. There was an employee/employer relationship.
  - c. The injury was within the course and scope of employment.

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<sup>3</sup> I have reviewed and considered all testimony and exhibits admitted into the record. Reviewing authorities should not infer from my specific citations to some portions of witness testimony and items of evidence that I did not consider those things not specifically mentioned or cited.

<sup>4</sup> Employer objected to the report of informal conference, which was identified on the record as CX-20, but was actually CX-16. In any event, CX-16, the report of informal conference, was admitted only for the limited purpose of establishing that it was held and not for any substantive issues. The record is unclear and inconsistent as to the identification of the actual exhibits. There may have been an inadvertent transposition of the terms claimant and employer when initially receiving the exhibits and there was confusion in the labeling of Employer's post trial exhibits. Although the transcript reflects that Claimant initially offered CX-1-43, he actually offered CX-1-30 and subsequently supplemented the record with CX-30-39. CX-39 is the transcribed oral ruling from Federal District Court in civil case 04-102 submitted post brief by Claimant without objection by Employer. He offered a document to impeach a witness (Tr. 167) and that document was referred to as his Exhibit 44, but it was never actually tendered to the Court. Claimant's counsel was contacted post trial and indicated he did not believe it was necessary for a complete record and waived its inclusion. In any event, the record is complete with the exhibits as listed herein and the transcript.

<sup>5</sup> CX-3.

2. There was timely notice and controversion.<sup>6</sup>
3. Claimant's average weekly wage as of the date of the alleged injury was \$451.40.
4. No compensation benefits have been provided.

### **FACTUAL BACKGROUND**

On 9 Jan 03, Claimant was working for Employer at a platform. He was engaged in offloading casing pipe from a tidewater vessel when he twisted his ankle. The exact description of the accident is in dispute. The parties dispute whether Claimant actually fell to the deck, injuring his back.

Claimant felt immediate pain in his ankle. He reported his ankle injury to Employer the day of his accident. He was seen by a physician assistant at Employer's medical facility. The physician assistant diagnosed a sprained ankle and released Claimant to return to work at full duty with no prolonged standing. Claimant went home to rest his ankle and subsequently began feeling back pain. He did not immediately return to work. He attempted to return to work on 16 Jan 03, but left work before his shift was completed due to back pain. He did not inform Employer that he was leaving work. He did not inform Employer that his back had started to hurt since his work accident.

The injury to Claimant's ankle has resolved and Claimant did not suffer an economic loss as a result of his ankle injury. Claimant seeks temporary total disability related to his back injury. He has received constant medical treatment for his back problems with various physicians. He has also been consistently prescribed pain medication. He has not worked since his attempt to return to work for Employer.

### **ISSUES**

Claimant alleges that as the crane operator lifted the load, it shifted. He went with the load and in the process stepped on a four by four board, injuring his ankle. He held onto the slings for support because he did not want to fall, even though the crane operator kept lifting the load. Eventually, Claimant let go, landing on his feet. He felt a searing pain in his ankle and fell to the deck, injuring his back. He seeks compensation for total disability and medical treatment for his back injury.

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<sup>6</sup> As to the ankle injury.

Employer responds that Claimant never fell, and if he did, the fall is not responsible for any back injury he may now suffer. It also denies responsibility for Claimant's past medical expenses because Claimant failed to obtain authorization. It further argues that Claimant's requested medical treatment is not necessary and that it had suitable alternative employment available for Claimant.

## **LAW**

### **Notice of Injury**

The Act bars claims unless the claimant notifies the employer of his work related injury within thirty days of the date the claimant becomes aware of the relationship between the condition or accident at work and his injury.<sup>7</sup> However, there is a presumption of timely notice and to invoke the bar; the employer must prove with substantial evidence that it has been unable to effectively investigate some aspect of the claim by reason of the claimant's failure to provide timely notice as required by Section 12.<sup>8</sup> There is no timely notice and a claim will be barred if an employer is prejudiced by being unable to investigate an accident or provide medical treatment.<sup>9</sup>

“While the disability due to one injury may be immediately appreciated, the existence and consequences of another injury may be unknown for months or years thereafter.”<sup>10</sup> The claim for an unknown injury is not barred by the passage of time. If a claimant provided employer with notice as to the original injury, such notice is sufficient when additional consequences arise from the original injury.<sup>11</sup> In addition, knowledge of a work related injury may be imputed to an employer “where the record indicates that employer knew of the injury and had facts that would lead a reasonable person to conclude that compensation liability is possible so that further investigation into the matter is warranted.”<sup>12</sup>

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<sup>7</sup> 33 U.S.C. § 12(a); *Thompson v. Lockheed Shipbuilding and Construction Co.*, 21 BRBS 94 (1988).

<sup>8</sup> 33 U.S.C. § 20(b); *Strachan Shipping Co. v. Davis*, 571 F.2d 968 (5th Cir. 1978), *Chase v. Bath Iron Works Corp.*, 22 BRBS 162 (ALJ) (1989) (employer has the burden of showing prejudice in order for a claim to be barred based on a lack of timely notice).

<sup>9</sup> *Addison v. Ryan-Walsh Stevedoring Company*, 22 BRBS 32 (1989); *Matthews v. Jeffboat, Inc.*, 18 BRBS 183, 187-188 (1986).

<sup>10</sup> *Marathon Oil Co. v. Lunsford*, 733 F.2d 1139, 1141 (5th Cir. 1984).

<sup>11</sup> *Lunsford*, 733 F.2d at 1141-1142; *Thompson*, 21 BRBS 94 (claimant gave timely notice regarding his work related ankle injury and therefore did not have to give additional notice as to his back problems that later arose from his ankle injury).

<sup>12</sup> *Mattox v. Sun Shipbuilding and Dry Dock Co.*, 15 BRBS 162, 165 (1982) (citing *Willis v. W.M.A.T.A.*, 12 BRBS 18 (1980); *Leyden v. Capitol Reclamation Corp.*, 2 BRBS 24 (1975); *Sun Shipbuilding & Dry Dock Co. v. Walker*, 590 F.2d 73, 9 BRBS 399 (3d Cir. 1978); *Strachan Shipping Co. v. Davis*, 571 F.2d 968, 8 BRBS 161 (5th Cir. 1978)).

Even if a claimant fails to provide a timely notice of injury under section 12, the resulting bar does not apply to a claim for medical benefits.<sup>13</sup>

### Compensable Injury

Section 2(2) of the Act defines “injury” as “accidental injury or death arising out of or in the course of employment.”<sup>14</sup> In the absence of any substantial evidence to the contrary, the Act presumes that a claim comes within its provisions.<sup>15</sup> The presumption takes effect once the claimant establishes a *prima facie* case by proving that he suffered some harm or pain and that a work-related condition or accident occurred, which could have caused the harm.<sup>16</sup>

A claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain.<sup>17</sup> These two elements establish a *prima facie* case of a compensable “injury” supporting a claim for compensation.<sup>18</sup>

If the work injury aggravates a pre-existing condition, the aggravation is compensable under the Act. Employers accept their employees with the frailties which predispose them to bodily injury.<sup>19</sup> A pre-existing condition is aggravated when a job related injury combines with or contributes to an underlying condition present prior to the work accident.<sup>20</sup> “[I]f employment factors aggravate, accelerate, or combine with a pre-existing disease to produce an accidental injury, the test of causation is satisfied.”<sup>21</sup>

The presumption does not apply, however, to the issue of whether a physical harm or injury occurred<sup>22</sup> and does not aid the claimant in establishing the nature and extent of disability.<sup>23</sup>

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<sup>13</sup> *Colburn v. General Dynamics Corp.*, 21 BRBS 219, 222 (1988); *Strachan Shipping Co. v. Hollis*, 460 F.2d 1108 (5th Cir.), *cert. denied*, 409 U.S. 887 (1972).

<sup>14</sup> 33 U.S.C. § 902(2).

<sup>15</sup> 33 U.S.C. § 920(a).

<sup>16</sup> *Gooden v. Director, OWCP*, 135 F.3d 1066 (5th Cir. 1998).

<sup>17</sup> *Kelaita v. Triple A Machine Shop*, 13 BRBS 326 (1981), *aff'd sub nom. Kelaita v. Director, OWCP*, 799 F.2d 1308 (9th Cir. 1986); *Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Building Co.*, 23 BRBS 191 (1990).

<sup>18</sup> *Id.*

<sup>19</sup> *J.B. Vozzolo, Inc. v. Britton*, 377 F.2d 144, 147-8 (D.C. Cir. 1967).

<sup>20</sup> *Strachan Shipping Co. v. Nash*, 782 F.2d 513 (5th Cir. 1986).

<sup>21</sup> *Gardner v. Bath Iron Works Corporation*, 11 BRBS 556 (1979).

<sup>22</sup> *Devine v. Atlantic Container Lines, G.I.F.*, 25 BRBS 15 (1990).

<sup>23</sup> *Holton v. Independent Stevedoring Co.*, 14 BRBS 441 (1981); *Duncan v. Bethlehem Steel Corp.*, 12 BRBS 112 (1979).

Although the Act must be construed liberally in favor of the claimant,<sup>24</sup> the “true-doubt” rule, which resolves factual doubts in favor of the claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act,<sup>25</sup> which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion.<sup>26</sup>

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners.<sup>27</sup> A claimant’s credible subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a *prima facie* case and the invocation of the Section 20(a) presumption.<sup>28</sup>

### **Medical Care and Benefits**

Section 7(a) of the Act provides that:

The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.<sup>29</sup>

An employer is liable for all medical expenses which are the natural and unavoidable result of a claimant’s work injury. For medical expenses to be assessed against an employer, the expenses must be both reasonable and necessary.<sup>30</sup> Medical care must also be appropriate for the injury.<sup>31</sup>

A claimant has established a *prima facie* case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition.<sup>32</sup>

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<sup>24</sup> *Voris v. Eikel*, 346 U.S. 328, 333 (1953); *Britton*, 377 F.2d 144.

<sup>25</sup> 5 U.S.C. § 556(d).

<sup>26</sup> *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct 2251 (1994), *aff’d* 900 F.2d 730 (3rd Cir. 1993).

<sup>27</sup> *Duhagon v. Metropolitan Stevedore Co.*, 31 BRBS 98, 101 (1997); *Avondale Shipyards, Inc. v. Kennel*, 914 F.2d 88, 91 (5th Cir. 1988); *Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce*, 551 F.2d 898, 900 (5th Cir. 1981); *Bank v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467, *reh’g denied*, 391 U.S. 929 (1968).

<sup>28</sup> *See Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff’d sub nom. Sylvester v. Director, OWCP*, 681 F.2d 359, 14 BRBS 984 (5th Cir. 1982).

<sup>29</sup> 33 U.S.C. § 907(a).

<sup>30</sup> *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979).

<sup>31</sup> 20 C.F.R. § 702.402.

<sup>32</sup> *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-258 (1984).

Section 7 does not require that an injury be economically disabling for a claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury.<sup>33</sup> Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury.<sup>34</sup>

An employer is not liable for past medical expenses unless the claimant first requested authorization prior to obtaining medical treatment, except in the cases of emergency, neglect, or refusal.<sup>35</sup> Once an employer has refused treatment or neglected to act on claimant's request for a physician, the claimant is no longer obligated to seek authorization from employer and need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury.<sup>36</sup>

The employer's refusal need not be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment.<sup>37</sup> Refusal to authorize treatment or neglecting to provide treatment can only take place after there is an opportunity to provide care, such as after the claimant requests such care.<sup>38</sup> Furthermore, the mere knowledge of a claimant's injury does not establish neglect or refusal if the claimant never requested care.<sup>39</sup>

## EVIDENCE

### *Claimant testified at trial in pertinent part that:*<sup>40</sup>

He was born on 10 Dec 65. He completed the 10<sup>th</sup> grade before taking some vocational training as a welder. He can read a tape measure, he cannot read a blueprint. In the early 1990s, he was in a car wreck. His shoulder and back were sore and he went to a doctor for about one month. However, he did not have any problems with his back between healing from the car accident until he was hurt on the job in January 2003.<sup>41</sup>

Although he worked for Employer before, his last period of employment with Employer started around July 2002. In January 2003, he went out to a platform by helicopter. He got dressed and ready for work and attended a safety meeting.

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<sup>33</sup> *Ballesteros*, 20 BRBS at 187.

<sup>34</sup> *Weber v. Seattle Crescent Container Corp.*, 19 BRBS 146 (1980); *Wendler v. American National Red Cross*, 23 BRBS 408, 414 (1990).

<sup>35</sup> *Schoen v. United States Chamber of Commerce*, 30 BRBS 103 (1997); *Maryland Shipbuilding & Drydock Co. v. Jenkins*, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979), rev'g 6 BRBS 550 (1977).

<sup>36</sup> *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294 (1988); *Rieche v. Tracor Marine*, 16 BRBS 272, 275 (1984).

<sup>37</sup> See generally, 33 U.S.C. § 907(d)(1)(A).

<sup>38</sup> *Mattox v. Sun Shipbuilding & Dry Dock Co.*, 15 BRBS 162 (1982).

<sup>39</sup> *Id.*

<sup>40</sup> Tr. 222-320.

<sup>41</sup> Tr. 222-224, 278-282.

Then he went to unload a boat. Since he was the only one that had a rigging card, he had a helper go with him. He does not recall the name of the helper, but it was a young firewatch guy.<sup>42</sup>

Claimant and the helper were lowered to the boat by a personnel basket. The deck of the boat was cluttered with trash, broken pallet boards, rocks, and shells. Claimant only had a few loads left when he was hooking up a pipe by putting straps under it and hooking it to the block. He was holding onto the straps to keep them from coming in when the load started up. It shifted and caused Claimant to twist his ankle. He moved with the load and stepped onto a four by four. It just blew his ankle out, hurting so bad that he held onto the straps because he did not want to put weight on his ankle. The load kept going up. Claimant did not want to be lifted off the deck, so he let go. He fell about one foot. He tried to land on his feet, but could not because his ankle was blown out. He landed on his tail bone.<sup>43</sup>

He crawled out of the way toward the wheel house, because he did not want to be under the load. The helper came and helped him walk to the wheel house, where they sat down. Claimant could feel tightness in his boot. Jackie Beard came down with the personnel basket and Claimant got in and was raised back to the platform. One of the workers helped Claimant go to the galley, where the Chevron and Employer representatives started filling out accident reports. Claimant told them he twisted his ankle on a four by four. He did not tell them about being picked up and falling to the deck because his back did not hurt at the time and he did not think it was necessary. They offered to send Claimant to a doctor, but he wanted to see if the swelling went down. He did not want to leave because he had just got there and needed the money. He decided to go to his bunk and stayed until the next morning. Various people came in to see how he was doing and asked what happened. He told them he twisted his ankle.<sup>44</sup>

His ankle was worse the next day. It was swollen, purple, and he could not walk on it. He had no choice but to go home and see a doctor. The Chevron supervisor, Jackie Beard, and Employer's foreman asked if Claimant wanted to stay, but there was nothing Claimant could do. A co-worker carried him to the deck where he took a helicopter back to land. An Employer van was waiting and took him to Lafayette. The driver asked what happened and Claimant told him he twisted his ankle. Claimant did not go into detail and did not think it was necessary at the time to mention the fall. The only thing he was worried about was his ankle. His ankle was in great pain and his back did not hurt at all.<sup>45</sup>

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<sup>42</sup> Tr. 224, 227-229.

<sup>43</sup> Tr. 229-232.

<sup>44</sup> Tr. 232-237.

<sup>45</sup> Tr. 237-239.

In Lafayette, Claimant saw an Employer medic. Claimant told him he twisted his ankle. He did not tell the medic the whole story, because at the time, it was just his ankle in pain. He had an x-ray and his ankle was injected with something that numbed it for a while. The medic said it was a light sprain, the ankle would get better, and Claimant could return to work. Claimant was not free from pain when he left the office. He did not tell Claimant to return in two days or give Claimant any medication.<sup>46</sup>

From there, Claimant went to Employer's office and took another van home. His ankle still hurt and he could not put weight on it. He went straight to bed. He told his girlfriend he had twisted his ankle. He stayed in bed for a couple of days. He lay down on his back with his feet up. Since his ankle hurt and he had no medication, he took some left over painkillers from his girlfriend. That was the only time he ever took her prescription. They did not completely relieve the pain, but they helped. The first morning he woke up at home his back was stiff and sore, but he thought it was from lying in bed. It was not like a sharp pain. It was just stiff, sore, and tight.<sup>47</sup>

He received a few calls from Employer while he was at home. After a day or so, Employer asked Claimant to go offshore. Claimant said he could not walk. He did not go into any details and just said he could not go. Employer called a second time a few days later and asked if Claimant could come into the shop for light duty. Claimant told him he would come in as soon as he could put his boots on. During that time, Claimant could not walk and was just lying in bed. His back was sore and stiff. He thought his back problems were from lying in bed. After about one week, Employer called again and Claimant went in the next day.<sup>48</sup>

Claimant went into Employer's shop on 16 Jan 03. Nobody knew he was coming. Eventually, a foreman finally found some welding for Claimant to do. He had a helper, but only part of the time. Claimant had to bend and stoop to weld. That is when his back started hurting. He started feeling sharp pains in his back down to his buttocks. He had been welding all his life, but never experienced any pain like that before. No one from Employer checked on him during the day. He worked eight hours that day. He did not tell anyone from Employer that his back was hurting because he figured if he went home and rested, it would quit hurting. His ankle swelled back up and he limped home on it.<sup>49</sup>

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<sup>46</sup> Tr. 239-241, 246.

<sup>47</sup> Tr. 240-242.

<sup>48</sup> Tr. 242-244.

<sup>49</sup> Tr. 244-250.

When he got home he went to bed. His back was more than just stiff and sore after the eight hours of welding. He told his girlfriend his back hurt and she asked him why. He explained what happened offshore. That was the first time he told her the whole story.<sup>50</sup>

Employer called Claimant and asked him to go offshore. Claimant said he could not because he was hurting. When Employer called back he said he was hurting, but he did not specify his back. At that point, the main reason he could not go to work anymore was not his ankle, it was his back. Claimant did not say his back was hurting because he was hoping it would go away and he could go back to work. Employer might have said something about light duty, but he is not sure after so many phone calls. He later testified that Employer told him that light duty work was available, but when he went back to work he was given welding work. He may have had other conversations with Employer after that first call, but is not sure. He called Employer a few times when his girlfriend started telling him to do something about his back still hurting. But when Employer did not return his calls, his girlfriend encouraged him to see a lawyer.<sup>51</sup>

He never received a letter from Employer at any time after 9 Jan 03 offering to set up a doctor's appointment for him. He never got a letter from Employer after 16 Jan 03 saying that it had a light duty program that he could work in.<sup>52</sup>

They went to see Les Waldeman and told his paralegal that Claimant's back and ankle were hurting. He does not remember the date they met. Claimant signed a LS-203.<sup>53</sup> He did not fill out box 24 or box 25. He does not remember who completed the form before he signed it. He did not tell them that he tripped and hurt his left knee. He does not know why CX-1 was filed with the Department of Labor in March 2003.<sup>54</sup>

The paralegal referred Claimant to a chiropractor, Dr. John Gudan. When Claimant went to Dr. Gudan, he filled out a form.<sup>55</sup> He did not say anything on the form about being lifted and falling to the deck. "No, I really don't write, I mean, write much or read. I mean, just that's all I put." He also stated he felt back and ankle pain immediately after the accident. The first time he felt the back pain radiating into his thigh was the day he welded and was bending and stooping. He

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<sup>50</sup> Tr. 250.

<sup>51</sup> Tr. 250-252, 317.

<sup>52</sup> Tr. 251.

<sup>53</sup> CX-1.

<sup>54</sup> Tr. 251-254.

<sup>55</sup> CX-8, p. 91.

did not get any relief of his back pain from the chiropractor. The ankle kept improving as time went on. Although the chiropractor could not prescribe medication, he had an MD that could. Therefore, Claimant started taking medication.<sup>56</sup>

Claimant's back still hurt too bad for him to work. His first attorney would never return calls, so he switched to Verona Steele. She interviewed Claimant and he told her about being picked up and falling to the deck. She appeared to hear and acknowledge his explanation of the accident. She sent Claimant to Dr. Samuel Greenberg at Westbank Health Care. He does not recall getting a copy of the 20 Feb 03 report from Advance Medical Rehab.<sup>57</sup>

Dr. Greenberg gave Claimant a no work slip, medications, and provided heat and electrical therapy current. Claimant's back pain kept getting worse. Claimant had an MRI and was told it showed a herniated disk. Dr. Greenberg sent Claimant to a neurosurgeon, Dr. Vogel. Claimant did not recall treating with Dr. Vogel ten years before. Dr. Vogel examined Claimant and wanted to run tests in the hospital. They discussed the possibility of surgery and Claimant agreed to have it if necessary because he was tired of hurting. Claimant got medication from Dr. Vogel.<sup>58</sup>

Claimant also saw Dr. Hubbell. Dr. Hubbell wanted to try injections. Claimant wanted to have that done, but his lawyer said they had to wait for Employer's doctor to see him. Claimant waited and waited. Dr. Hubbell gave Claimant pain medication in November 2003 and a couple of refills after that. When Claimant ran out of medicine he got aggravated. When his lawyer was not getting anything done, he fired her. She did authorize Claimant to go back to Westbank Health Care Center in June 2004, but just for medicine to hold him over. He continued to get some electric therapy, but it did not help. His ankle was healing and might have been healed by then. His back was hurting.<sup>59</sup>

Claimant went back to Dr. Vogel before Hurricane Katrina. He recommended surgery. After Katrina, Claimant moved to West Monroe. He saw a Dr. Mogan at the pain clinic there. He writes Claimant prescriptions. Claimant complained to Dr. Mogan about his calf and thigh getting smaller.<sup>60</sup>

He recalls seeing Dr. Katz in Marrero on 30 Nov 03. The exam was fast and quick, ten minutes at the most. He did not measure Claimant's thigh and calf, even though Claimant told him one of his legs was shrinking.<sup>61</sup>

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<sup>56</sup> Tr. 254-257.

<sup>57</sup> Tr. 257-258.

<sup>58</sup> Tr. 258-261.

<sup>59</sup> Tr. 261-264.

<sup>60</sup> Tr. 264.

<sup>61</sup> Tr. 264-265.

Claimant went back to Dr. Vogel the next week. He drove that morning all the way and got aggravated when he found out they did not have his records. He returned to Dr. Vogel about one month later. Dr. Vogel measured Claimant's leg and said Claimant needs immediate surgery. Claimant has been unable to work since the initial injury in January and wants to have the surgery. Claimant has children and wants to get better. He also wants to return to work.<sup>62</sup>

Dr. Manale gave Claimant some prescriptions on 24 Mar 06. His appointment with Dr. Manale was scheduled for around the same time as Dr. Mogan. Claimant did not return to Dr. Mogan because he already had prescriptions. He has no plans to return to Dr. Mogan. He takes the medication for pain. He does not feel good about how many he takes daily, but he has to take them for pain. If he does not have the surgery then he needs his medication.<sup>63</sup>

Right before the hurricane, he went with his MRI studies to see a Dr. Chiverton in New Orleans East with Access Pain Management. He needed some pain medicine. Dr. Chambers had released Claimant in July 2005, because he could not write Claimant any more prescriptions. She did give Claimant one last prescription, which Claimant filled at Folse pharmacy. Claimant did not fill a prescription from Dr. Chambers on the same day that he filled a prescription from Dr. Chiverton. He told Dr. Chiverton he was not seeing any other doctors at the time. He never told anyone at Dr. Chiverton's office that he had been released from Dr. Chambers on 27 Jun 05 and since then had no medicine except his girlfriend's medication. He told them that he was waiting "on surgery, waiting on something, got to do something." He got Lortabs and Somas from Dr. Chiverton.<sup>64</sup>

He may have had an appointment in August 2005 with Dr. Vogel. Claimant did not tell Dr. Vogel that he was seeing Dr. Chiverton because he did not get any medicine from Dr. Vogel. Dr. Vogel did not write Claimant a prescription and if he did, Claimant did not fill it.<sup>65</sup>

About one week after the hurricane Claimant moved to West Monroe. He still lives there. He goes back to New Orleans at least twice a month because he still has the house in Gretna. He stays with friends or in a hotel. He does not stay in the house in Gretna. He started seeing Dr. Mogan there and saw him every month

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<sup>62</sup> Tr. 265-266.

<sup>63</sup> Tr. 266-268.

<sup>64</sup> Tr. 269-271.

<sup>65</sup> Tr. 271-272.

until March 2006. He thinks he got his prescriptions from Dr. Mogan in Monroe and filled them at Drennan's Pharmacy. There may be another one, but he does not remember. Claimant has also filled prescriptions at Walgreens and Folsom pharmacies.<sup>66</sup>

Claimant has applied for Social Security Disability benefits and understands that if he is working, he can not receive them. He has not applied for any unemployment since January 2003.<sup>67</sup>

Claimant was familiar with Employer's safety and training policy concerning the reporting of accidents and injuries. He was supposed to report them soon as possible to his foreman or any superior. He did not do that in this case because he wanted to go back to work and needed the money.<sup>68</sup>

After his back started hurting, Claimant tried to call Troy Hux a couple of times. He got an answering machine and just left a message for Troy Hux to call Claimant back. Mr. Hux never returned the calls.<sup>69</sup>

Employer has a 24-hour dispatcher number where workers could leave messages. Claimant would use that number to contact the dispatcher. He never left a message with the 24-hour dispatcher for Troy Hux or anybody else at Employer to return his call concerning his back problem. Claimant never tried to get in touch with anyone else at Employer to have them return his call.<sup>70</sup>

The handwriting on Employer's injury report<sup>71</sup> looks like his, except the lower portion. He did not write that he fell. He does not write. He does not read that well. He did not tell anyone that he fell because he thought it was just his ankle at the time.<sup>72</sup>

The handwriting in box 24 for the LS-203<sup>73</sup> is not Claimant's handwriting. He cannot say why the paralegal that filled out the form did not put that he fell because he told her that he did. The handwriting in the "How did the incident occur" box of the contractor injury report<sup>74</sup> is not his. The handwriting on the worker's compensation accident form<sup>75</sup> is his and he filled out the information.<sup>76</sup>

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<sup>66</sup> Tr. 273-278, 285.

<sup>67</sup> Tr. 283-285.

<sup>68</sup> Tr. 289-291.

<sup>69</sup> Tr. 291-292.

<sup>70</sup> Tr. 292-294.

<sup>71</sup> EX-34.

<sup>72</sup> Tr. 294-295.

<sup>73</sup> EX-16.

<sup>74</sup> EX-21.

<sup>75</sup> EX-25.

<sup>76</sup> Tr. 295-299.

Between 10 and 16 Jan 03, Claimant did not ask Employer to make a doctor's appointment for him. From 16 Jan 03 and on, Claimant did not ask Employer to make a doctor's appointment for him. He did not ask Employer or the U.S. Department of Labor (DOL) to authorize treatment with Dr. Gudan or the other doctors at the chiropractic clinic. When Claimant changed doctors to Dr. Greenberg and the physicians at his office he did not ask Employer or DOL to authorize that treatment. When he went to see Dr. Vogel, he did not ask Employer or DOL to authorize that treatment. When he went to see Dr. Hubbell, he did not ask Employer or DOL to authorize that treatment. When he began seeing Dr. Deiparine and Dr. Chambers in 2004, he did not ask Employer or DOL to authorize that treatment. When he went to see Dr. Chiverton, he did not ask Employer or DOL to authorize that treatment. When he began seeing Dr. Mogan, he did not ask Employer or DOL to authorize that treatment. When he saw Dr. Manale, he did not ask Employer or DOL to authorize that treatment. When he saw Dr. Shamsnia, he did not ask Employer or DOL to authorize that treatment. Claimant never received a letter from Employer to offer to set up a doctor's appointment for him.<sup>77</sup>

Claimant is not sure if he signed pain management contracts with Dr. Chiverton, Dr. Hubbell, Dr. Mogan, or Dr. Chambers. He signed a stack of papers and they could have been in there. Claimant does not recall if Dr. Hubbell, Dr. Chiverton, or Dr. Mogan explained what pain management was, but they may have. Claimant was told he was only supposed to get medication from one physician, but does not recall being limited to one pharmacy to have those prescriptions filled.<sup>78</sup>

The last time Claimant received pain medication from Dr. Mogan was 24 Feb 06. He got a prescription with a refill. He was supposed to see Dr. Mogan again on 24 Mar 06, but saw Dr. Manale instead. He does not have any other appointments scheduled with Dr. Mogan. He had Dr. Manale's prescription filled when he saw him on 24 Mar 06. He had it filled somewhere on the Westbank, but not at Folse.<sup>79</sup>

Dr. Vogel gave him prescriptions in January 2006. He did not tell Dr. Vogel that he did not need the prescriptions, but he did not get them filled. He has no idea why he did not tell Dr. Vogel he did not need the prescriptions.<sup>80</sup>

Claimant met with Mr. Fentress, a vocational specialist. He did not ask Mr. Fentress to provide job placement assistance. He has not asked anybody with DOL to provide him with vocational rehabilitation. When Claimant owned the vending machine business he separated the money out at various establishments.

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<sup>77</sup> Tr. 299-306, 316.

<sup>78</sup> Tr. 303-305.

<sup>79</sup> Tr. 305-309.

<sup>80</sup> Tr. 310-312.

He also performed daily repairs on the vending machines, which required the use of a butterfly nut and flathead screwdriver. He also did routine maintenance on the machines.<sup>81</sup>

Claimant received several no work slips from his doctors. Claimant never submitted those slips to Employer.<sup>82</sup>

***Claimant's girlfriend testified at trial in pertinent part that:***<sup>83</sup>

In January 2003, she had been living with Claimant for 3 or 4 years. Claimant is quiet, laid back, passive, and easy going. He is a pushover. She has to drag things out of him just to have a conversation with him. He is not much of a reader or a writer. Before his accident in 2003, she never knew him to have any problems with his back.<sup>84</sup>

When Claimant came home on 9 Jan 03, he had his boot in his hand and was limping. She asked what happened and he said he busted his ankle. He said he twisted it on a board or something like that. With the help of her son, she put Claimant in bed and elevated and iced the ankle. He said his ankle hurt like "crap." She gave Claimant a Percocet or Percodan that she had from a prescription from a few months earlier. The next morning Claimant said he was still hurting and his ankle was swollen. He said he was stiff, sore, and achy. Over the next week the swelling went down in Claimant's ankle and it appeared to be getting better. Claimant was stiff and sore, she guessed, from lying in bed all week. Claimant continued taking her Percodan or Percocet. That was the only time she gave him any of her prescriptions.<sup>85</sup>

Either the same day he came home or the next, Troy Hux called and she answered the telephone. He wanted Claimant to come back to work. She told him Claimant could not even walk. They had another phone conversation the day before Claimant went back to work on 16 Jan 03. That is why he went back to work. Claimant talked to Troy Hux and told him there was no way he could go offshore because he could hardly walk. Claimant agreed to try light duty the next day.<sup>86</sup>

When he went to work the next day, he still complained of being stiff and sore. His ankle was bothering him a little bit. It was not like it was before and he thought he would be fine. When he came home from work, Claimant said there was no way he could work. He said his back was killing him. She asked him if he hurt his back and he said not really. She asked him why his back was hurting and

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<sup>81</sup> Tr. 312-313.

<sup>82</sup> Tr. 314-315.

<sup>83</sup> Tr. 321-365.

<sup>84</sup> Tr. 321-324.

<sup>85</sup> Tr. 327-331.

<sup>86</sup> Tr. 330-333.

he said he guessed it was from when he fell on his behind. She asked when that happened and he told her at work when they started to lift him up, he let go because he did not want to go up with the load. That was when he fell down.<sup>87</sup>

After the day when Claimant came home and said his back was hurting him, Employer called the house again. Claimant answered the phone. He said he was hurt, could not work offshore, and was not coming back to work. Troy Hux wanted Claimant to work offshore and Claimant said he could not do it. That is all he said. She got mad at him for not telling Employer what was hurting him and why. They got in a big fight about it. Claimant never told her that he was supposed to go back to the doctor two days after he hurt his ankle. Claimant called Troy Hux back the same day and then a few times the next day because she made him. She had called Troy Hux herself. When she did, they connected her to his line. If he did not pick up there was an answering machine. Claimant left two phone messages for Troy Hux. One was right after he worked that day 16 Jan 03. The other was the next day. After Claimant left the two messages for Troy Hux, he did not do much other than lie in bed. He said he had sharp pains running down his back or his spine and down his leg and back. Claimant cannot do much except for lie in bed because of his pain. He is getting progressively worse. He is suffering.<sup>88</sup>

The telephone at their house had a caller ID system. She checked it every time she went out. If someone had called and Claimant did not answer the phone, it would have shown up in the caller ID. When Employer had called before the accident their calls were shown on the ID. She saw no calls from Employer on the caller ID from the time Claimant made two phone calls to Troy Hux up to Katrina.<sup>89</sup>

When Troy Hux did not call back, they went to a lawyer. He did not want to go, but she made him. Claimant does not like confrontation and he did not want to cause problems with Employer. She went with Claimant to see the lawyer, Lester Waldeman. Mr. Waldeman and a paralegal met with her and Claimant. The meeting was rushed. Claimant signed some papers. He signed a LS-203,<sup>90</sup> but the handwriting in boxes 24 and 25 is not Claimant's. Claimant cannot write well and she could read boxes 24 and 25. Those blocks were blank when Claimant signed the form. Claimant gave the whole story during the meeting. She was there to make sure he did. Claimant said both his ankle and his back were hurting. She has no clue why the form was not sent to the Department of Labor until 18 Mar 03. The lawyer referred Claimant to a chiropractor for his back pain.<sup>91</sup>

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<sup>87</sup> Tr. 333-334.

<sup>88</sup> Tr. 334-336, 339.

<sup>89</sup> Tr. 332-335, 339-340.

<sup>90</sup> CX-1.

<sup>91</sup> Tr. 335-339.

Lester Waldeman would not return phone calls, so Claimant switched to another attorney, Ronna Steele. When they met with her, she looked distracted. She kept fiddling around with things while Claimant was talking. She would nod her head then write stuff down. She referred Claimant to a second group of doctors. They did not help Claimant. They gave him medication. She does not know if Claimant got medicine from the first doctor.<sup>92</sup>

Claimant has not worked for money since those eight hours in January 2003 and she does not think that he could. All he does now is run errands and watch the kids. He watches a lot of television. There is not much Claimant can do because he cannot stand for too long. Claimant cannot cook or cleanup. His back is now the worst it has ever been. It keeps getting worse. Claimant told her that Dr. Vogel wanted Claimant to have surgery. Claimant wants to get fixed and wants his life back. She has noticed a change in Claimant's legs. One leg is smaller than the other, mainly from the knee down.<sup>93</sup>

Claimant has run out of medication before. He starts hurting and is miserable and fights tears. He also gets chest pains. She has seen him get physically sick from the pain. Claimant feels he is getting addicted to his medication and cannot stand it. He wants a normal life. He wants to have the surgery to get his life back. He does not want to just survive and live the rest of his life taking pain medication. Claimant is willing to try anything to make his back better. His attorney, Steele, was supposed to set up an appointment for epidural injections, but she came up with excuses and told him that Employer's doctor had to see Claimant first before she could schedule any appointments. Claimant went to a pain clinic the same day he got a prescription from Dr. Vogel because the doctor "didn't give him his medicine and he needed a doctor because he goes through that chest pain and anxiety attack looking thing and tears in his eyes. And he was going to go find a doctor..." Claimant did not fill the medications Dr. Vogel gave him because they were different than the ones he has been taking for years.<sup>94</sup>

In 2004 she had a prescription for Lortab for three to six months. She did not receive medication from any other doctor after she stopped receiving the Lortab. She got the Lortab at Walgreen's on either Gretna Boulevard or Stumpf Boulevard. She presently has a prescription for medication for migraines. She and Claimant have not seen the same doctors or gone to the same pharmacies since he was injured in 2003. She does not know if she has ever received a prescription for Vicodin or Upsar.<sup>95</sup>

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<sup>92</sup> Tr. 339-342.

<sup>93</sup> Tr. 342-344, 347.

<sup>94</sup> Tr. 344-346.

<sup>95</sup> Tr. 347-357, 360-362.

Since they evacuated to West Monroe, Claimant has returned to the New Orleans a couple of times. Since Claimant's accident in 2003 they have had one daughter together. She was born at the end of 2003. He used to help take care of her when she was little, but now she is too big for him to pick up or play with. He cannot run after her either.<sup>96</sup>

The handwriting in the bottom entry of Employer's injury report<sup>97</sup> looks like Claimant's handwriting. The handwriting in the "How did the incident occur" box of the contractor injury report<sup>98</sup> does not look like Claimant's. The handwriting on lines 6 and 10 of the workers' compensation accident form<sup>99</sup> is Claimant's.<sup>100</sup>

***Octave Jackson testified at trial in pertinent part that:*<sup>101</sup>**

On 9 Jan 03 he was working for Employer on a work crew with Claimant, Kevin Bellow, and Noah Snell. When the personnel basket came down to the boat Claimant got off, stepped on a four by four, and twisted his ankle. He did not see Claimant lifted into the air. When Claimant fell back, he broke his fall with his hands. Claimant fell on a slope and it was a controlled fall. Claimant's ankle was swollen and he went to the galley and the bunk house. He did not go into the galley with Claimant. He did not see the contractor injury report<sup>102</sup> being completed. He just signed the report. He was not there when the rest of the form was filled out. The superintendent asked Claimant if he wanted to call an emergency flight for him to go in that day. Claimant said he wanted to see if his ankle swelling would go down. Claimant's ankle got bigger the next day. Claimant could not walk on it, so Mr. Jackson carried Claimant to the heliport on his back. He never heard Claimant complain of back pain.

***Kevin Bellow testified at trial in pertinent part that:*<sup>103</sup>**

On 9 Jan 03, he was the paint foreman of Claimant's crew. He was standing on the handrail a couple of feet away from Jackie Beard. The boat was to his left and out of his view. He did not see the accident, but heard an initial report about it on his radio. He does not know if Jackie Beard saw the accident, although he may have testified at his deposition that he did not believe Jackie Beard could have seen it from where he was standing.<sup>104</sup>

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<sup>96</sup> Tr. 357-359.

<sup>97</sup> EX-34.

<sup>98</sup> EX-21.

<sup>99</sup> EX-25.

<sup>100</sup> Tr. 362-363.

<sup>101</sup> Tr. 137-144.

<sup>102</sup> EX-21.

<sup>103</sup> Tr. 145-174.

<sup>104</sup> Tr. 145-153.

Claimant was brought up to the platform and taken to a room so they could do an accident report. Mr. Bellow does not recall other employees being in the room with him and Claimant. It was part of his job to do an accident investigation and a report. He asked the crane operator, Jackie Beard, Octave Jackson, and Noah Snell if they saw the accident, and they all said they did not. If anyone would have said they had seen the accident he would have had them fill out a statement.<sup>105</sup>

He does not know Tyler Leger, but it is possible that he could have been a fire watch rigger on the platform. He does not remember him being there. If Tyler Leger was a fire watchman, he should have been assigned to off load the tidewater boat only if he was rigger certified.<sup>106</sup>

He signed the contractor's accident report.<sup>107</sup> He completed the form based on what Claimant told him. Claimant never told him that he had fallen. They also completed an accident form for Employer.<sup>108</sup> Claimant completed the statement block himself and said "Unloading boat, hooked up load, backed up to get away from load and stepped off a four by four, twisted ankle [sic]." The rest was filled out based on what Claimant said. He does not recall any of the other Employer personnel approaching him and asking what had happened. Although he reported how the accident occurred, Mr. Bellow did not see the accident happen. He completed the report based on what Claimant told him.<sup>109</sup>

After the accident, Claimant stayed on the platform for the night. He has not seen Claimant since he left the platform. The first time he learned that Claimant was alleging that he had a back injury was on 13 Mar 06, when he got a letter from Claimant's attorney.<sup>110</sup>

***Noah Snell provided a recorded statement which provided in pertinent part that:***<sup>111</sup>

He witnessed Claimant's accident. Claimant was holding onto the slings before the load was picked up and the crane operator picked up the load without signaling. Claimant lost his step on a piece of wood. Claimant fell and hit the deck, busting his ankle. Mr. Snell did not see Claimant hit his elbows, but saw Claimant's foot slip out from under him. Claimant merely stepped on something; it was not the crane operator's fault.

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<sup>105</sup> Tr. 152-154.

<sup>106</sup> Tr. 159-160, 165-167.

<sup>107</sup> EX-21.

<sup>108</sup> EX-34.

<sup>109</sup> Tr. 154-158, 160-162.

<sup>110</sup> Tr. 158-159.

<sup>111</sup> EX-33.

***Christian Werner testified at deposition in pertinent part that:*<sup>112</sup>**

He was at the controls of the tidewater vessel on which Claimant was injured on 9 Jan 03. He was watching two men rig cargo, hook it up to the crane, and signal for it to be lifted. During one of the last loads, he saw Claimant standing on a pipe. As he stepped off the pipe, he slipped and stumbled. He had a hand on the sling, but it was slack and did not stop him from falling. He fell on his side and ended up on the deck. He did not fall very hard because the sling broke some of his fall. He did not recall who was signaling that load, but the load was never lifted while Claimant was involved. The load was not lifted and Claimant's simply tripped and fell.

***Jerry Sims testified at deposition in pertinent part that:*<sup>113</sup>**

He was the engineer on the tidewater vessel at the time of Claimant's injury. He saw Claimant fall on his rear while he was rigging cargo. Claimant was helped up and dusted himself off. Claimant was having trouble with his ankle and hobbling. He helped Claimant over to the paint locker. Claimant said he felt like he had sprained his ankle.

***Wesley Williams testified at deposition in pertinent part that:*<sup>114</sup>**

He was operating the crane on 9 Jan 03, when Claimant was injured. They had two lifts left. They were hooking up straps on a bundle of pipe. Claimant had the slings in his hands. Claimant backed up, looked up, and stepped on a 4-by-4, twisting his ankle. Claimant fell to the deck very hard, falling on his butt and his side. He did not lift the load while Claimant was holding the straps. He immediately hooked up the personnel basket, and Jackie Beard went down to get Claimant. He lifted Claimant and Jackie Beard to the platform.<sup>115</sup>

After about 20 minutes, he went into the living quarters and saw Claimant lying down flat on his back with a swollen and bruised ankle. He checked on Claimant periodically throughout the afternoon. Claimant never complained of back injuries or back problems or back pain. Claimant only mentioned his ankle.<sup>116</sup>

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<sup>112</sup> EX-7; CX-5.

<sup>113</sup> CX-35.

<sup>114</sup> CX-4.

<sup>115</sup> CX-4, pp. 9-13.

<sup>116</sup> CX-4, pp. 34-37.

***Jackie Beard testified at deposition in pertinent part that:*<sup>117</sup>**

In January 2003, he was a workover representative in the cased hole group. He was responsible for ordering Employer's crew, including Claimant. Two people were needed to offload the tidewater vessel. Claimant was one and the other was either Tyler Lege or Noah Snell.<sup>118</sup>

While they were offloading the equipment, he was standing on the handrail watching the operation. The vessel was about seventy-five to one hundred feet below the platform and off to his left. He would watch for 15 or 20 minutes at a time. He did not see Claimant fall to the deck of the vessel. He saw Claimant stumble as he stepped backwards off of a 4-by-4. Claimant had his right hand holding onto a nylon strap and did not fall all the way onto the deck. Claimant never fell to the deck. Jackie Beard never saw Claimant hit his back. Claimant could not have fallen on his back without him seeing it.<sup>119</sup>

Claimant was giving the signal to the crane operator, but at the time of the accident he had not given the signal to hoist the load up. Claimant hooked the load up, but never gave the signal to pick the load up.<sup>120</sup>

Claimant continued to hold the load after he stumbled. That is what kept him from falling to the deck. If he would not have had his hand on the sling, Claimant probably would have fallen down. He is not sure if Claimant signaled the crane operator on the first load that they hoisted. The load was not lifted at the time Claimant stumbled.<sup>121</sup>

Claimant was limping across the deck on both of his own two feet. The other employee helped Claimant back to the front of the boat. He knew Claimant was hurt so he went down on the personnel basket and got Claimant into it. They rode up together and went into the quarters. Claimant took his boot off and his ankle was swelling. They elevated and iced Claimant's ankle and filled out reports.<sup>122</sup>

Claimant did not want to be sent in. Mr. Beard wanted Claimant to go back on the helicopter, but Claimant refused. Claimant wanted to see if he could get back to work. He told Claimant to rest for the rest of the day and keep the ankle iced. They decided to wait until the next morning. By then, the ankle was swollen even

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<sup>117</sup> EX-4.

<sup>118</sup> EX-4, pp. 8-12, 23-27, 35-36.

<sup>119</sup> EX-4, pp. 50-57.

<sup>120</sup> EX-4, pp. 64-67.

<sup>121</sup> EX-4, pp. 67-71.

<sup>122</sup> EX-4, pp. 71-73.

more. Octave Jackson gave Claimant a piggyback ride to the helicopter and that was the last he saw of Claimant.<sup>123</sup>

The only thing Claimant ever mentioned hurting was his ankle.<sup>124</sup>

At the time he saw Claimant stumble, Kevin Bellow and Octave Jackson were setting a piece of equipment down behind him on the platform. Neither of them was at the handrail with Mr. Beard. He cannot say if either of them saw Claimant stumble.<sup>125</sup>

***Jamie LaFleur testified at deposition in pertinent part that:***<sup>126</sup>

He does not have any independent recollection of Claimant and did not recall the facts of Claimant's accident until he reviewed the reports while he was interviewed by Employer's attorney.<sup>127</sup>

In January 2003, he worked as a Regional Safety Manager for Employer. He gave safety orientation classes to new employees, visited job sites; watched for safe work practices, was responsible for reporting any injuries that occurred. He was the Western Regional Director and his area was from Morgan City west to Houston and Galveston.<sup>128</sup>

On 10 Jan 03, he received a call from the owner/operator on the platform that they had an injured employee being flown to Intercoastal City. He picked Claimant up. Claimant limped out to his truck and his ankle was swollen. While they were heading to the doctor, he talked to Claimant about what happened and why. It was about a 45-minute ride.<sup>129</sup>

Claimant said he was standing on one of the pipe bundles and that he hooked up that pipe bundle using nylon straps. Then he said he backed up to allow the load to be lifted. He did not say that the load had been lifted or that the crane operator had lifted the load in any way. Claimant did not say he was holding onto any slings at the time the load was being lifted. He said he was stepping onto the 4X4

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<sup>123</sup> EX-4, pp. 73-78.

<sup>124</sup> EX-4, p. 107.

<sup>125</sup> EX-4, pp. 111-112.

<sup>126</sup> EX-5; CX-7.

<sup>127</sup> EX-5, pp. 16-18, 35.

<sup>128</sup> EX-5, pp. 8-12.

<sup>129</sup> EX-5, pp. 18-19.

wooden block from the pipe rack when his ankle twisted, forcing him to fall to the boat deck. Claimant did not say anything about a load being lifted as causing him to lose his balance. Claimant specifically said that he tried to step onto the 4X4 as opposed to stepping onto the deck. Claimant did not report that he injured his back in the accident that he described.<sup>130</sup>

They went to the Acadiana Healthplex in Lafayette, where Claimant had a complete examination. They were told Claimant could return to full-duty work. He does not know if Claimant understood that he was being released to full work duty, even though he was told so. Employer provided a ride for Claimant to return home.<sup>131</sup>

He completed the Root Cause Analysis<sup>132</sup> based on what Claimant told him. Had Claimant reported a back injury, it would be reflected on the Root Cause Analysis.<sup>133</sup>

He then handed the case over to the regional manager for the New Orleans area.<sup>134</sup>

***James Carruth testified by deposition in pertinent part that:***<sup>135</sup>

He is a certified licensed physician's assistant. In 2003, he was affiliated with Acadian Healthplex. His primary field was occupational medicine and he was working under the direction of Dr. Olga Reavill.<sup>136</sup>

On 10 Jan 03, Claimant presented with a history of twisting his left ankle on 9 Jan 03. He did not report falling and gave no history of back problems. An x-ray was taken and was negative. The ankle was swollen, bruised, and painful. The diagnosis was acute ankle strain. Claimant was given an injection in the ankle to block the nerve. It also reduces swelling and inflammation. He was not given a prescription, but advised to take over the counter medication. Claimant was also advised to elevate, ice, and immobilize the ankle. Claimant was released to full duty so long as there was no prolonged standing. Claimant was to return for a follow up in 48 hours to insure there was no small hairline fracture missed due to the swelling.<sup>137</sup>

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<sup>130</sup> EX-5, pp. 25-26, 29, 36.

<sup>131</sup> EX-5, pp. 19-21.

<sup>132</sup> EX-12.

<sup>133</sup> EX-5, pp. 18, 22, 26-27.

<sup>134</sup> EX-5, p. 61.

<sup>135</sup> EX-6; CX-6; EX-10 (medical records).

<sup>136</sup> EX-6, pp. 10-18.

<sup>137</sup> EX-6, pp. 18, 20-26, 32; EX-10, pp. 2-4.

Claimant was present when Employer's safety representative was given a copy of Claimant's release and told to bring Claimant back for a follow up. He would have expected Claimant to keep the ankle iced, elevated, and rested for a couple of days, but many employers will accommodate those requirements at work, so they do not have to report a lost time injury.<sup>138</sup>

It is possible that a patient would be in so much ankle pain that they might not notice another problem. A disc compromising a nerve is a pretty significant injury and if Claimant had that, he would have let the doctors know he was in pain. The local injection in the ankle would not have masked any back pain.<sup>139</sup>

***Donny Faust testified at trial and by deposition in pertinent part that:*<sup>140</sup>**

In January 2003, he was Employer's Health, Safety and Environmental manager in the eastern region. He dealt with offshore accidents, investigating accidents, and orientation of employees. His counterpart in Lafayette was Jamie LaFleur. He does not know Claimant.<sup>141</sup>

Jamie LaFleur contacted him to see if Claimant could work onshore at the Harvey facility and make sure everything was okay. Jamie LaFleur also mentioned that Claimant needed a follow up appointment upon coming back to work, but did not say that Claimant's physician's assistant wanted Claimant back in two days for an evaluation. It is Employer's standard practice to follow a doctor's or physician's assistant's recommendations regarding injured employees.

It is not his responsibility to go track someone down in their neighborhood to take them to a doctor's appointment. Claimant was released to full duty, but may have been subject to qualifications as discussed between Jamie LaFleur and James Carruth. Claimant came to Harvey and worked for one day, but then walked off the job, so Employer never arranged that follow up appointment. He attempted to contact Claimant at his house, at least four times throughout that week, but never reached Claimant.<sup>142</sup>

Employer's policy concerning recording work related accidents is that employees are to immediately report any injury to their direct supervisor, who will fill out a report and send that directly to the safety manager for that location. Any time an employee needs medical treatment he can call the 24 hour dispatcher. It is not an

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<sup>138</sup> EX-6, pp. 32-33, 40-44, 47-48.

<sup>139</sup> EX-6, pp. 52-56, 62.

<sup>140</sup> Tr. 427-465; CX-26.

<sup>141</sup> Tr. 427-428.

<sup>142</sup> Tr. 428-430, 434-435; CX-26, pp. 10-13.

answering machine. The dispatcher calls the safety manager of that area. The safety manager then immediately lines up a doctor's visit for the employee.<sup>143</sup>

Upon receiving a full duty release from the doctor, Claimant was sent to the Harvey office. The plan was for Claimant to work in the yard at the Peters Road facility, doing whatever he could tolerate. Claimant came in the first day at six. When he arrived at eight, Claimant was already working, and not expressing any complaints or issues. About midway through the day, the yard superintendent approached and asked if he knew what happened to Claimant. That is when he found out that Claimant had walked off the job without notifying him or the yard superintendent. If Claimant felt physically unable to perform the job, he should have gone to the yard superintendent and explained what was going on. They would have made sure that Employer did not overstep any boundaries on putting him to work. Even though Claimant was on a full duty release with no restrictions, Employer still watches over employees to make sure they get up to speed. On a full duty release, an employee comes in to work to see how he works and adjusts his job based on what he can and cannot do.<sup>144</sup>

Employees know if there is an issue while they are working, they are to report it. There is a safety meeting before every work day starts in the yard. Every safety meeting informs them that if they have any injuries to report it immediately to the superintendent. The yard superintendent knew that Claimant was injured in an offshore accident, had a full duty release, and was coming to work in the yard.<sup>145</sup>

Claimant never complained to him of a back injury and the first time that he learned Claimant had sustained a back injury was a month or so before the hearing.<sup>146</sup>

Employer's modified duty or return to work program is based on the employee's injury and what type of release he receives from the doctor. The employee can work in any number of functions. They could work at the tool house issuing tools or just logging tools out. They could work in the office doing paperwork or answering phones.<sup>147</sup>

Normally in the case of a follow up appointment, he would make sure with the initial attending physician that it was okay to follow up with a physician on the eastern side. If that doctor refused, then they would transport the employee back

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<sup>143</sup> Tr. 429-431, 436.

<sup>144</sup> Tr. 430-433, 435.

<sup>145</sup> Tr. 432-433.

<sup>146</sup> Tr. 433.

<sup>147</sup> Tr. 433-434.

to the existing doctor. If not, then he would line up the two doctors to have a telephone conference to discuss the employee's complaints. In Claimant's case, he did not contact Dr. Reavill or James Carruth concerning Claimant because he did not have time to do it before Claimant walked off the job.<sup>148</sup>

He never received a telephone message from Claimant or his girlfriend following Claimant's accident. If Claimant had contacted him to complain of either back pain or ankle pain, he would have immediately brought Claimant in to see a doctor. Claimant did not tell him he was leaving before the end of the shift. He never talked to Claimant after that day.<sup>149</sup>

He did not send Claimant a letter telling him Employer wanted to take him to a doctor. While Claimant worked in the yard he did not go out and ask Claimant how he was doing. If Claimant had an issue he was made aware that he needed to report it.<sup>150</sup>

In his experience, physicians do not comment on an employee's health or restrictions outside the presence of the employee. The employee is always issued a copy of his release.<sup>151</sup>

***Troy Hux testified at trial and by deposition in pertinent part that:*<sup>152</sup>**

In January 2003, he was a personnel manager for Employer. He assisted in Claimant's hiring. When Claimant was hired, he went through an orientation process covering all of Employer's policies and procedures pertaining to safety and the reporting of any accidents and injuries.<sup>153</sup>

If an employee is injured he must report it to his immediate supervisor upon the accident happening. His immediate supervisor will then call the safety department and Employer responds accordingly to the location of the injured employee to make sure he gets immediate attention. Once an employee is brought in from offshore, he is eventually transported back to his home. After the person is transported home, if he has additional complaints of pain, he should contact Employer immediately. Claimant should have contacted either him or Don Faust, the area safety man. Employees are required to report complaints of work related pain and they are instructed as such at the beginning of basically every job.<sup>154</sup>

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<sup>148</sup> Tr. 435-437.

<sup>149</sup> Tr. 437-438.

<sup>150</sup> Tr. 440-442, 445-446.

<sup>151</sup> Tr. 452-453.

<sup>152</sup> Tr. 367-426; CX-25.

<sup>153</sup> Tr. 367-369; CX-25, p. 7.

<sup>154</sup> Tr. 369-371.

When Claimant was injured, Employer had a modified return to work program. It was based on the person's skill level and what kind of work he can produce for Employer while he recovers. Claimant's class level would have qualified him to perform some kind of duty for which he was hired. Otherwise, there were some other duties available. Claimant could have either been in the tool room assisting with getting tools out to the yard or doing some light clerical type of work. If an employee was placed in a position under the modified work program, and he reported that he was physically unable to perform those duties, Employer would definitely follow through and get him some additional medical help. Then, it would take appropriate steps to make other employment positions available.<sup>155</sup>

He learned of Claimant's injury from the safety department. He talked to Jamie LaFleur about it. He understood that Claimant had some type of foot injury. Claimant never contacted him to complain of any type of ankle or back pain. He has never received a call from Claimant's girlfriend concerning Claimant's injuries. He never received a message from Claimant or his girlfriend after Claimant returned to work. As personnel manager, he is required to return all calls and messages left by employees and if Claimant had left a message after he worked in the modified light duty program, he would have called Claimant back.<sup>156</sup>

Claimant ultimately participated in the modified duty program and was assigned to do some yard welding at the Harvey facility on land. It was stationary work and did not require him to climb anything. He could take breaks. If Claimant had physical difficulties completing this type of work, he should have notified the yard superintendent or the lead foreman on that particular job task. According to the yard superintendent, Claimant did not complete his shift and did not contact anybody to let them know that he was leaving. Claimant should have notified management before leaving. His office is at the facility where Claimant was working. Had Claimant or his girlfriend told him that Claimant was having complaints of pain, he would have contacted Claimant and gotten Mr. Faust involved. He would have found other job tasks for Claimant to do. Employer would have sought medical treatment to accommodate Claimant. He does not necessarily have to consult a physician before locating a job that an employee feels he can physically perform.<sup>157</sup>

Typically when someone calls and he is not available, they will get the receptionist and she would put them through to voicemail or take a message. There is someone answering phones 24 hours a day.<sup>158</sup>

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<sup>155</sup> Tr. 371-372.

<sup>156</sup> Tr. 372-374, 388; CX-25, pp. 13-14.

<sup>157</sup> Tr. 375-377, 407; CX-25, pp. 11-13, 19-20.

<sup>158</sup> Tr. 377.

Claimant underwent and passed a pre-employment physical.<sup>159</sup>

After the date of the accident, he contacted Claimant and offered him an offshore job.<sup>160</sup>

He did not know the physician's assistant wanted Claimant to be seen in two days for a follow up. He did know there was an additional follow up visit to be done. He did not have a time line on it. He understood Claimant to have a full duty release the day of the accident. He was not told that James Carruth released Claimant to full duty, but with no prolonged standing. It would have been Employer's protocol to bring Claimant back to Carruth in two days for a re-evaluation. He has never seen Carruth's report on Claimant.<sup>161</sup>

A day or two after Claimant was injured; he called Claimant to offer him an offshore job. He called Claimant more than once after his accident on 9 Jan 03 and when Claimant showed up at the yard on 16 Jan 03. He does not recall Claimant saying he could not come because he was hurt. Claimant never called to complain of any additional pain or discomfort as it relates to the injury. The second time he called Claimant, he offered Claimant a light duty position. He told the yard superintendent Claimant was coming in for light duty. Claimant was to do welding in the yard the day he showed up for light duty. Welding can be a light duty task. Claimant was accommodated based on his willingness to come to work in the yard. He did not have any medical input as to what those accommodations needed to be. The light duty welding required Claimant to stand for 12 hours, bend, and stoop. However, to his knowledge Claimant did not have any weight restrictions.<sup>162</sup>

He receives up to 300 phone calls a day and works 10 to 14 hours per day. He gets to work at 8:00 in the morning and would not have been there if Claimant arrived at six. He did not check to see if Donny Faust made the doctor's appointment for Claimant's follow up. During the day of light duty, Claimant would have been working in a crew with a foreman. His and Donny Faust's offices are at the Harvey location where Claimant was working. Claimant had been to the office before and knew where it was.<sup>163</sup>

His understanding was that Claimant had had an ankle twisting injury and had been cleared by the medical staff to return to full duty. He did not know anything specific about a 48 hour follow up. Claimant did not immediately return to work, but Employer did not have work for him anyway. He believed Claimant could have gone offshore, but there was not much work. It was happenstance that there

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<sup>159</sup> Tr. 380-381.

<sup>160</sup> Tr. 386, 391.

<sup>161</sup> Tr. 390-392, 396; CX-25, pp. 15-17.

<sup>162</sup> Tr. 391-394, 396-402, 406; CX-25, pp. 20-22.

<sup>163</sup> Tr. 402-404.

was an influx of work in the Harvey facility and they needed Claimant to do some welding. He called Claimant to come into the yard because that was where the work was, rather than any consideration for Claimant's physical condition. It was not really, "We have some light duty for you." It was, "We have a job for you." He called Claimant in because he had work for him. It did not have anything to do with modified duty. In Mr. Hux's mind, Claimant could have gone back offshore. However, in his deposition Mr. Hux testified that Claimant was given a light-duty welding position when he returned to work on 16 Jan 03.<sup>164</sup>

After the one day of welding he called Claimant and left messages, but Claimant did not call back. After about a month, he decided Claimant was not going to call back and he quit trying. He called Claimant three to five times, telling Claimant that Employer had work for him and to please call back. However, during his deposition he testified that he was sure that someone called Claimant after he left work on 16 Jan 03, but he did not know who called, if in fact, a call was made.<sup>165</sup>

He had no idea Claimant's back was injured until Claimant filed this claim.<sup>166</sup>

#### Medical Testimony and Evidence

***Dr. John Gudan testified at trial in pertinent part that:***<sup>167</sup>

He is a board-certified chiropractor. He discontinued his practice in the field of chiropractic medicine in August 2005 and is now in reconstruction. He does not independently recall Claimant.<sup>168</sup>

Claimant first presented to him on 6 Feb 03 from a referral by his attorney. Claimant filled out some initial forms, including a workman's compensation form.<sup>169</sup> Claimant filled that out in his own handwriting. Claimant complained of left ankle pain, low back pain radiating to his anterior thigh and groin region and neck pain, in addition to stomach pain, abdominal pain, and occipital headache pain.<sup>170</sup>

Claimant gave an oral history also. Claimant came in reporting ankle and back pain. He asked Claimant how the back was hurt. Claimant reported he twisted his left ankle on a four by four under the load they were lifting. He fell and caught

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<sup>164</sup> Tr. 414-417; CX-25, pp. 24-25.

<sup>165</sup> Tr. 417-419, 424-425; CX-25, p. 23.

<sup>166</sup> Tr. 426.

<sup>167</sup> Tr. 182-222.

<sup>168</sup> Tr. 182-188, 192.

<sup>169</sup> CX-8, p. 55.

<sup>170</sup> Tr. 188-190.

himself on the block. He went back up to his feet, let go, fell back down again, and landed on his back and side. He experienced immediate ankle pain, and later low back pain radiating to his anterior thigh/groin area, neck pain, and headaches.<sup>171</sup>

He examined Claimant and conducted a number of tests on Claimant's back. The straight leg raising test was positive on the right at 75 degrees. The Fabre Patrick Test was positive on the right. The Braggard's Test was negative. He cannot recall the significance of a negative Braggard's Test in Claimant's case. He has not been studying chiropractic medicine for the last six or seven months and does not remember that one. He concluded Claimant had low back sprain, strain, and contusion. He recommended Claimant have x-rays and some physical therapy.<sup>172</sup>

He treated Claimant again on 18, 24 and 27 Feb 03 and 18 and 25 Mar 03.<sup>173</sup>

On the 18 Feb 03, Claimant's primary complaint was low back pain, although he still had left ankle pain. Claimant underwent flexion distraction and had physical therapy. On 24 Feb 03, Claimant reported low back pain and improvement in the ankle. He recommended Claimant have flexion distraction. When there are disk problems he tries to use flexion distraction to help decrease the pain, decrease the swelling, and increase range of motion. Flexion distraction is manipulation, but it is not an adjustment.<sup>174</sup>

On 18 Mar 03, Claimant complained of low back pain and tenderness. Claimant said he could not lie down. Claimant received physical therapy. On 25 Mar 03, Claimant's complaint was low back pain. That visit, they did a pull move adjustment.<sup>175</sup>

Based on his review of the records, standard procedure would have been to place Claimant on temporary total disability for at least three weeks, and it would have been continued past 25 Mar 03. He does not know if Employer was sent a letter stating that. He thinks they should have done an MRI.<sup>176</sup>

Claimant was still symptomatic on his last visit on 25 Mar 03. Based on the history provided by Claimant and his findings, he believes Claimant's complaints were caused by the accident on 9 Jan 03.<sup>177</sup>

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<sup>171</sup> Tr. 190-192.

<sup>172</sup> Tr. 193-195, 210-218.

<sup>173</sup> Tr. 196.

<sup>174</sup> Tr. 196-198, 204.

<sup>175</sup> Tr. 198-199.

<sup>176</sup> Tr. 199-201.

<sup>177</sup> Tr. 201.

The only thing that is a cause for suspicion of disc involvement would be Claimant's reported radiating pain to the anterior thigh. There is no reference in Claimant's records to disk pathology at all. After his initial interview and examination of Claimant on 6 Feb 06, there were no further reports of radiating pain to the anterior thigh. But that could be indicative that Claimant was responding positively to the treatment. Claimant never reported any radicular pain or radiating pain after 6 Feb 03.<sup>178</sup>

There is no mention of a diagnosis of spondylolisthesis by any doctor at the chiropractic clinic. It is doubtful that a grade I spondylolisthesis could cause the type of symptom complex that Claimant reported in February of 2003 or the pain that Claimant reported later. A lumbar strain or sprain could, but normally resolves on average in three to six months.<sup>179</sup>

The history Claimant gave him is different from the history as set forth in initial injury reports. None of the documents he reviewed referenced Claimant falling down or injuring his back.<sup>180</sup>

***Dr. Victor Flynn testified at deposition in pertinent part that:*<sup>181</sup>**

He is a board-certified chiropractor. In 2003, when his practice was called Associated Chiropractic, he had an affiliation with Dr. Krivitsky and Dr. Wood. They saw patients in his clinic. Dr. Krivitsky and Dr. Wood are medical doctors. They evaluated patients that needed pain management, medical evaluations, and assessments.<sup>182</sup>

Claimant was referred to his office in 2003 by his attorney. Claimant completed a New Patient Evaluation Sheet and mentioned that he was a workers' compensation patient, so he also filled out a Worker's Compensation Accident Form. He put on the form that he felt immediate pain after the accident in his ankle and back. Claimant was seen by Dr. John Gudan.<sup>183</sup>

In his history, Claimant indicated he had been in a motor vehicle accident eight years before, for which he was treated for neck and back pain. Claimant indicated he received treatment for one to two weeks and then the pain resolved. Claimant was stable from the motor vehicle injury prior to his 2003 work accident.<sup>184</sup>

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<sup>178</sup> Tr. 201-203.

<sup>179</sup> Tr. 203-204.

<sup>180</sup> Tr. 206-209, 220-221; EX-34; EX-16.

<sup>181</sup> CX-8; CX-2.

<sup>182</sup> CX-8, pp. 8-12.

<sup>183</sup> CX-8, pp. 12-17.

<sup>184</sup> CX-8, pp. 27, 86; CX-2, p. 1.

Claimant complained of left ankle pain, lower back pain radiating to the anterior thigh groin region, neck pain, occipital headaches, and stomach pain greater on the right side. The straight leg raise test was positive on the right at 75 degrees. The Fabre's test, which tests for hip pathology and lower back pain, was positive on the right for increasing lower back pain. Claimant demonstrated a negative Braggard's sign. That test is a nerve tension test and if positive, it indicates nerve root irritation.<sup>185</sup>

Claimant returned to the clinic on 6 Feb 03. Claimant received physical therapy and Dr. Flynn reviewed Claimant's x-rays with him. He referred him to Dr. Wood for evaluation of the hernia in the stomach and pain management.<sup>186</sup>

Based on his experience with patients with conditions like Claimant's, he feels that Claimant should reach maximum therapeutic improvement over three to six months of care. Based on Claimant's subjective complaints, he would have deferred any recommendation about Claimant's ability to work until they had more testing done and more information about the proposed type of work. In the meantime, he would classify Claimant as on total temporary disability based on the nature of Claimant's complaints, the lack of any job descriptions, and the lack of significant diagnostic testing. Claimant was capable of ambulation and sitting or standing for part of an eight hour day. If Employer had called on 31 Mar 03 and asked him to approve Claimant for a desk job eight hours a day alternating sitting and standing to accommodate any position change that Claimant needed, he possibly would have approved that. He would have been cautious to return Claimant to work.<sup>187</sup>

Dr. Flynn only treated Claimant on two occasions. The only evidence that Dr. Flynn had that Claimant was having any physical problems was his subjective complaints of pain. However, the initial examination with Dr. Gudan documented objective findings.<sup>188</sup>

***Dr. Edmond Wood testified at deposition in pertinent part that:*<sup>189</sup>**

He is board-certified in emergency medicine. In 2003, he had his own practice and also did some independent contractor work for some other offices in the New Orleans area, including Advanced Medical Rehab (AMR) on the Westbank. AMR was a chiropractic office with a focus on physical rehabilitation of injured patients. Dr. Krivitsky was also affiliated with that office.<sup>190</sup>

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<sup>185</sup> CX-8, pp. 20-22, 40-42; CX-2, p. 2.

<sup>186</sup> CX-8, pp. 43-51.

<sup>187</sup> CX-8, pp. 62-70, 84; CX-2, p. 4.

<sup>188</sup> CX-8, pp. 70-71.

<sup>189</sup> EX-3; CX-24.

<sup>190</sup> EX-3, pp. 6-10.

He first saw Claimant on 12 Feb 03. He does not have any independent recollection of that encounter, but reviewed the records. Claimant gave a history of back injury and left ankle pain. Claimant's history was negative for paresis, paresthesia, dysesthesia, and incontinence, which are symptoms associated with spinal cord injuries or nerve root injuries.<sup>191</sup>

On physical examination, he determined that Claimant was in mild to moderate distress. He evaluated Claimant's back and neck. Claimant did not report any neck pain. On lumbar evaluation, Claimant had two-plus tenderness with mild muscle spasm and somewhat restricted range of motion with pain. There was pain associated with the range of motion testing. The diagnosis was low back pain and lumbar myofascial strain or contusion. Myofascial means muscle and fascia means the connective tissue surrounding the muscles. This is a type of injury that is frequent with acceleration or deceleration. Basically, it is deep tissue bruising from microtears or even macrotears. It would be uncommon to see bruising on the back because it is a deeper injury. His initial examination on 12 Feb 03 did not show Claimant to have any evidence of peripheral nerve injury or nerve root impingement secondary to a herniated disc or so forth.<sup>192</sup>

He placed Claimant on a moderate non-narcotic or semi-narcotic analgesic along with a muscle relaxant, and recommended physical therapy twice a week. He does not recall placing Claimant on any duty restrictions, but it appears that the chiropractor returned him for light duty. He probably would have limited Claimant's ambulation, standing, bending, and stooping. He definitely would have limited climbing and lifting.<sup>193</sup>

On 19 Feb 03, Claimant reported he had unrelieved pain and requested a different medication. He did a brief review of systems and physical examination with no new results. He changed Claimant's medication from Tramadol and Flexeril to low dose Lortab and Skelaxin. He does not recall asking Claimant to turn in the previous prescription from the week before. Since neither Tramadol nor Flexeril are controlled substances it would not have been a major concern. That was Claimant's last visit. At that stage, there was no urgent or emergent need for either an MRI or any other diagnostic test.<sup>194</sup>

Based on Claimant's history and description of the back pain being caused by twisting his ankle, catching himself on the block of the crane, lifting back up, and falling back down on his back side was the cause of his back pain, Dr. Wood believes the pain could have been a result of the trauma of the accident.<sup>195</sup>

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<sup>191</sup> EX-3, pp. 12, 19-21.

<sup>192</sup> EX-3, pp. 24-31, 54.

<sup>193</sup> EX-3, pp. 32-39.

<sup>194</sup> EX-3, pp. 39-44.

<sup>195</sup> EX-3, pp. 53-54.

***Dr. Charles Aprill testified at deposition in pertinent part that:*<sup>196</sup>**

He is a radiologist by training and board certification whose practice is limited to the assessment of adult spine disorders. His only reviewed Claimant's ankle MRI scan and a lumbar spine MRI scan. He never had any verbal or physical contact with Claimant.<sup>197</sup>

He interpreted the films of a 28 May 03 lumbar spine MRI. His impression was isolated disc pathology at L5-S1 with moderately advanced nuclear degradation and disc degeneration and left posterolateral disc protrusion compromising the mid and exit zone of the left L5-S1 root canal. He did not note a spondylolisthesis and did not mention it in his report it as such. In retrospect, if someone were to say there is a minimal spondylolisthesis, he could not argue it, but he did not report it then and would not report it now. If it was spondylolisthesis he would grade it as much less than a Grade I. He did make an error in his report, but it did not involve missing spondylolisthesis. He believes there was a shift of L5-S1.<sup>198</sup>

Upon reviewing the 30 Jun 05 stand-up MRI, he saw a Grade I spondylolisthesis at the L5-S1 level. He could not opine whether the condition of Claimant's lumbar spine as shown in the 28 May 03 MRI could have progressed to the Grade I spondylolisthesis in the 30 Jun 05 MRI because the answer is not a simple yes or no.<sup>199</sup>

The 28 May 03 MRI shows Claimant had a condition known as spondylolysis at L5. Spondylolysis is an acquired condition, usually acquired in adolescence. He suspects that Claimant developed his spondylolysis probably at age 12 to 14. There is a break in a bone called pars interarticularis, which is a common condition occurring in approximately 8 to 10 percent of the adult population in North America. It is usually minimally symptomatic and it is usually associated with age with some degeneration or deterioration of the disc at that level, most common at the L5-S1 level. He missed the spondylolysis on the 28 May 03 scan. Spondylolysis is rarely associated with progressive spondylolisthesis. By the time a subject is 20 to 25 years of age, whatever slip that will occur has occurred. Absent some additional stress or problem, spondylolisthesis as a result of L5 spondylolysis does not progress.<sup>200</sup>

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<sup>196</sup> CX-10.

<sup>197</sup> CX-10, pp. 5-15.

<sup>198</sup> CX-10, pp. 21-23, 26.

<sup>199</sup> CX-10, pp. 23-25.

<sup>200</sup> CX-10, pp. 25-28.

Claimant has spondylolisthesis at L5-S1 that is more obvious on the 30 Jun 05 scan than it was on the 28 May 03 scan. Therefore it has progressed. A factor in relation to that progression is that the L5-S1 disc has undergone considerable degeneration between 2003 and 2005. As the disc degenerates and the disc space narrows or the disc settles, the vertebral body at L5 slipped forward.<sup>201</sup>

A fall such as was described did not cause the spondylolysis. It predated that. A fall such as described did not cause the degeneration of the L5-S1 disc as it is seen on the 28 May 03 scan. That degree of degeneration is more advanced than he would expect to occur in the interval between January and May of 2003. But there is a small disc protrusion. That disc protrusion could have been caused by the fall injuring an already degenerating disc. The only way to disprove that, and actually the only way to prove it, would be to have a scan that predates the fall so that he can compare the two.<sup>202</sup>

A fall onto the buttocks from a standing height is a common and sufficient cause of injury to the lumbar discs and might well be expected to injure an already damaged or vulnerable disc. That certainly could have accelerated or caused the accelerated degeneration of the L5-S1 disc.<sup>203</sup>

The word "herniation" is inappropriate for describing disc pathology because it is incomplete. A contained disc herniation is called a protrusion. A non-contained disc herniation is called an extrusion. A fragment that has migrated freely, which means a totally dissociated herniation, is called an extrusion. Herniation is incomplete unless qualified by contained, non-contained, or migrated. A disc bulge is a focal distortion of disc contour, not a herniation. A protruding disc is a contained herniation.<sup>204</sup>

Claimant's abnormality was difficult to classify because it was broad enough that it might simply be a focal bulge. The disc protrusion mass effect of the L5-S1 disc was abutting the left L5 nerve as it traverses that root canal, but an MRI does not show whether it is applying an extrinsic pressure on that nerve. Whether that protrusion is solely the result of this disc degenerating or whether it is related to an injury is something an MRI does not differentiate. He can not say whether that protrusion was present the day before he fell or as a result of the fall. He can say that the disc was moderately advanced in its degeneration before he fell. Claimant had moderately advanced disc degeneration at the L5-S1 level before 9 Jan 03.<sup>205</sup>

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<sup>201</sup> CX-10, pp. 27-28.

<sup>202</sup> CX-10, pp. 29-30.

<sup>203</sup> CX-10, pp. 30-31.

<sup>204</sup> CX-10, pp. 31-33.

<sup>205</sup> CX-10, pp. 33-37.

A 35-37 year-old man with L5 spondylolysis and a degenerating disc at L5-S1 need not be symptomatic. The condition is usually asymptomatic. A fall onto the buttocks could injure the vulnerable L5-S1 disc, but he cannot testify that it did. If the patient did not complain of pain before, but did have pain shortly after a fall onto the buttocks, it is more likely than not that there is a cause-and-effect relationship.<sup>206</sup>

The 30 Jun 05 MRI shows an actual tear of the wall of the annulus fibrosis at the L4-5 level and tear of the annulus wall at L5-S1, but both of those are contained protrusions so the outermost layer is still intact. The 2005 MRI film is consistent with a progressive deterioration of the L5-S1 level. The L4-5 discs look normal on the 2003 scan, but are certainly not normal now on the 2005 scan. There is an unquestionable change between 2003 and 2005 at the L4-5 level. There is now mild degeneration and a contained protrusion, or protrusion or contained herniation, that wasn't evident on that previous scan. At L5-S1, there is degeneration which has definitely progressed from the 2003 scan, but there is still an eccentrically left-sided disc protrusion at L5-S1, which is broader but still recognizable as the protrusion that was present before.<sup>207</sup>

He cannot say that the posterior herniation of the L4-5 disc could relate to a trauma on Jan 03. Patients can sustain disc injury that progresses from annular tear to protrusion over time. An injury can occur and the protrusion may not actually become apparent until months or even years later. Claimant's protrusion at 4-5 is not associated with any features that allow an estimation of its age and that disc is not very degenerated. That would make him think that the injury of this disc occurred relatively recently. He does not believe the 4-5 protrusion is 5 years old, but cannot say it is not 2 or 3 years old.<sup>208</sup>

At L5-S1, there is no question as to progression, and in that sense, a case can be made for injury occurring at 5-1 in January and the progressive changes occurring between 2003 and 2005. L4-5 cannot be assessed the same way. It is possible that the disc at 4-5 was injured so that an annular fissure occurred as a result of that and that fissure propagated over time to a full protrusion. By the same token, this could have occurred in the absence of that trauma or as a result of some subsequent incident. The L4-5 could have been injured and not manifested, but that is not more probable than not.<sup>209</sup>

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<sup>206</sup> CX-10, pp. 38-39.

<sup>207</sup> CX-10, pp. 40-43.

<sup>208</sup> CX-10, pp. 43-45.

<sup>209</sup> CX-10, pp. 45-48.

At 5-1, he can say that the likelihood that the progression occurred was related to some trauma, particularly a trauma in January 2003 reaches the level of more probable than not. At L4-5, he cannot say one way or the other.<sup>210</sup>

Abnormal mechanics or anatomy because of the progressive slip may or may not have caused the problem at 4-5 because that disc becomes abnormal in many subjects without trauma.<sup>211</sup>

He believes that the 2005 MRI scan shows that the L3-4 disc is normal.<sup>212</sup>

Atrophy in the left thigh and calf would be consistent with the pressure of the L5-S1 nerve roots as seen in the 2005 MRI.<sup>213</sup>

He believes that prior to January 2003, Claimant had a bilateral L5 spondylolysis, which is an abnormality occurring at the L5 level and involving a portion of the L5 vertebra and its processes. Spondylolysis is defined as a defect in the pars interarticularis of L5. The defect is generally considered to be a chronic stress fracture. Spondylolysis at L5 is common, usually appearing at or near adolescence, peaking somewhere between 12 to 14 years of age. Claimant also had moderately advanced nuclear degradation.<sup>214</sup>

The spondylolisthesis shown on the 2005 MRI was not traumatically induced in January 2003. A traumatically induced spondylolisthesis would be apparent on the May 2003 scan if it had occurred as a result of direct trauma. The spondylolisthesis is likely related to degeneration that occurred at the 5-1 disc and that slip would not be expected to occur in the absence of some extraneous force or event.<sup>215</sup>

Spondylosis is generally accepted as a term which includes the maturation and degeneration that occurs in the human spine over time. Spondylolysis is the defect in the pars which occurred as an adolescent. Spondylolisthesis is a slip of one vertebra onto the second, and that appears to have occurred with Claimant or has certainly progressed in between the two scans.<sup>216</sup>

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<sup>210</sup> CX-10, p. 48.

<sup>211</sup> CX-10, pp. 53-54.

<sup>212</sup> CX-10, p. 58.

<sup>213</sup> CX-10, pp. 60-62.

<sup>214</sup> CX-10, pp. 62-64.

<sup>215</sup> CX-10, pp. 64-71.

<sup>216</sup> CX-10, pp. 72-80.

The level of success of decompression stabilization at L5-S1 with lytic spondylolysis and spondylolisthesis is not close to 100 percent. The complication rate associated with that procedure and the failure rate is not insubstantial. He would plan on any posterolateral fusion at L4-5 failing. If the 4-5 disc is causing Claimant any back pain, a posterolateral fusion at 4-5 will leave Claimant with a damaged back and a painful 4-5 disc. Anterior interbody fusion at 4-5 and probably an anterior interbody fusion at 5-1 with posterior instrumentation is major surgery. He would be more conservative and try to decrease Claimant's level of pain and improve his level of function. It is not going to be possible to eliminate Claimant's back pain or leg pain. Minimally invasive conservative techniques have a chance to reduce the level of pain and improve the level of function, but could fail.<sup>217</sup>

The disc protrusion at L5-S1 could have pre-existed or could have developed after the trauma. It could have been caused by a fall from standing or sitting height, or a rapid twisting or shearing force associated with a fall or a direct blow. It could have been caused by simply being involved in heavy manual labor. Something had to happen to cause it.<sup>218</sup>

Isthmic spondylolysis at the L5 level with trauma rarely causes pain. A patient with disc degeneration at the L5-S1 level has back pain without any memorable event. A patient who has a combination of an isthmic spondylolysis at the L5 level and disc degeneration at the L5 level can have back pain without a memorable event, but it is usually caused by the disc and not the isthmic spondylolisthesis.<sup>219</sup>

***Dr. K.E. Vogel testified at deposition in pertinent part that:*<sup>220</sup>**

He is board-certified in neurosurgery. Hurricane Katrina destroyed his patient records, but Claimant's attorney provided him a copy of Claimant's records for 14 Jul 03, 11 Aug 03, 7 Nov 03, and 9 Aug 05. He also was able to review Claimant's lumbosacral MRIs from 28 May 03 and 30 Jun 05.<sup>221</sup>

His billing records show that he treated Claimant in 1993 for lumbar sprains and strains. Claimant had been involved in an accident and was treated by Dr. Greenburg who referred Claimant to him.<sup>222</sup>

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<sup>217</sup> CX-10, pp. 93-97.

<sup>218</sup> CX-10, pp. 109-112.

<sup>219</sup> CX-10, pp. 125-127.

<sup>220</sup> CX-12.

<sup>221</sup> CX-12, pp. 6-8.

<sup>222</sup> CX-12, pp. 9-11, 31.

On 14 Jul 03, Claimant was again referred to him by Dr. Greenberg for lumbosacral pain. Claimant was not on any medications and related being in good health until he was "hooking up a crane and got twisted and fell." Claimant reported subsequently experiencing left ankle pain as well as lumbosacral pain. Claimant had been treated conservatively prior to that time, but related persistent lumbosacral pain. Claimant reported he had not returned to his normal duties as a welder since that time. Claimant denied any prior injuries. His neurological examination of Claimant revealed a 37-year-old patient in no acute distress. Claimant's positive neurological findings were limited to the low back. Lumbosacral examination revealed a severe degree of limitation of motion with flexion limited to 20 degrees. There was severe muscle spasm. There was no scoliosis. Straight leg-raising test was negative and motor and sensory examinations were normal. Reflexes were plus-two and there was tenderness of the facets bilaterally. The May 2003 MRI revealed a small disc extrusion at L5-S1 to the left.<sup>223</sup>

There was no mention of left ankle pain on that date and it appeared that the left ankle injury had resolved. At that time, he felt Claimant either had a herniated disc or symptomatic lumbar degenerative disc disease. He suggested continued conservative care with Dr. Greenberg. He favors conservative care because 90 percent of his patients get well without surgery.<sup>224</sup>

In July 2003, he could not have provided limitations or restrictions that could define parameters for a modified duty job for Claimant because Claimant was under active treatment and he did not know what kind of work Claimant was capable of doing. If he were a jeweler, Claimant might have been able to work, but even then the pain might have been too great.<sup>225</sup>

Claimant returned for a follow-up on 11 Aug 03. At that time, Claimant had low back and right hip pain. Claimant continued to have limited range of motion and muscle spasm. Neurologically, he remained intact. Dr. Vogel recommended Claimant have a lumbar discogram/CAT scan to determine the etiology of the ongoing pain. That was not performed, so on 7 Nov 03, he wrote to Dr. Greenberg and advised him that he was discharging Claimant back to him. Because the procedures had not been scheduled or performed Dr. Vogel believed Claimant remained disabled from his work as a welder.<sup>226</sup>

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<sup>223</sup> CX-12, pp. 9, 17-22.

<sup>224</sup> CX-12, pp. 22, 25-27 34.

<sup>225</sup> CX-12, pp. 32-34.

<sup>226</sup> CX-12, pp. 35-36.

He did not see Claimant again until two years later, on 9 Aug 05, when Claimant was referred back by Dr. Greenberg for an evaluation of Claimant's low back pain and with numbness in the left lateral foot. An examination again revealed limited range of motion, muscle spasm, and a new finding of scoliosis to the left. Claimant remained neurologically intact. Dr. Vogel reviewed the June 2005 lumbar MRI done by Dr. Glorioso and agreed with the radiologist's report. While the prior studies only revealed suspicion of a herniated disc, there was now a mechanical problem where there is actually a slippage of one vertebra onto its neighbor, technically called lumbar spondylolisthesis, at L5-S1. A later X-ray in November 2005 confirmed spondylolysis, which is the defect that is necessary to allow a spondylolisthesis to occur. Spondylolysis is the defect in the arch. Spondylolisthesis is the actual slippage. Claimant did not have any different or additional symptoms reported at the August 2005 office visit that were an indication of the lumbar or lumbosacral spondylolisthesis. Claimant primarily had findings of mechanical problems in his back, which is consistent with that pathology of spondylolisthesis and symptomatic lumbosacral disc disease.<sup>227</sup>

Claimant returned to him on 7 Dec 05. Claimant had been under the care of Dr. Joseph Morgan. Claimant reported he was still having pain in his back and numbness. He told Claimant there was no point in proceeding until they could recreate his records.<sup>228</sup>

He re-evaluated Claimant on 9 Jan 06 for lumbosacral pain and bilateral leg numbness. Claimant reported the pain had become intractable. Claimant had continued conservative care and had no other intervening treatment. An examination revealed mild limitation of motion and flexion was limited to 70 degrees. There was moderate muscle spasm bilaterally and mild scoliosis to the right. The straight leg-raising test was negative and motor examination was limited by pain. Claimant's right thigh measured 47 centimeters and his left measured 43 centimeters. Claimant's right calf was 36 centimeters and his left was 33 centimeters. Claimant had about an inch of atrophy of both the thigh and the calf on the left. Claimant had a lumbar spondylolysis with a Grade 1 spondylolisthesis and early atrophy of the left lower extremity.<sup>229</sup>

Atrophy in the left lower leg is an indication of nerve root compression and a loss of neurological support for those muscles. He suspects that testing will show the vertebrae has slipped and scissored the nerves between the openings, which, in addition to the disc herniation, is causing nerve root compression on that side. The

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<sup>227</sup> CX-12, pp. 37-39, 44-48.

<sup>228</sup> CX-12, p. 48.

<sup>229</sup> CX-12, pp. 48-50.

first time he noted definitive objective findings or symptoms of compression of the nerve root in his lumbosacral spine was the atrophy in January 2006.<sup>230</sup>

In addition to the disc at L5-S1, Claimant has evidence of a disc bulge at L4-5. Claimant needs a discogram at 3-4, 4-5 and 5-1, with L3-4 being the control.<sup>231</sup>

He believes that Claimant's disc herniation along with the spondylolisthesis combine to create a greater overall disability. If the discogram turns out to be positive at one or more levels, Claimant will need a fusion. A fusion is a major surgery and would take Claimant about two years to recover from. He disagrees with Dr. Katz's opinion that Claimant does not need surgery. Claimant has atrophy of his leg that is getting worse and cannot be ignored. Claimant is not at maximum medical improvement. Claimant is currently disabled from any type of employment. Given the findings on 30 Jun 05, he believes that Claimant was in such a level of pain that he probably would not have been able to work or concentrate.<sup>232</sup>

It is hard to say if the herniation at the L5-S1 level would that create the type of instability that would cause herniations at L3-4 and L4-5 levels. Degenerative disc disease can be progressive in the low back. Claimant has an unstable segment at L5-S1 and there easily could be progression of the disease above it. That occurs in 10 to 15 percent of cases.<sup>233</sup>

Claimant already has atrophy of his leg, which means that nerve is not working. If it goes on too long, it will become permanent and the next step will be loss of bladder and bowel control.<sup>234</sup>

He believes Claimant's signs and symptoms are causally related to the January 2003 incident, whatever the pathology eventually turns out to be, and whether there are one, two, or three disc herniations. As of January 2006, Claimant remained disabled from any type of employment due to his back pain and atrophy.<sup>235</sup>

***Dr. Paul Hubbell testified at deposition in pertinent part that:***<sup>236</sup>

He is board certified in anesthesiology and pain management. The goal of interventional pain management is to try to identify the cause of the pain and

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<sup>230</sup> CX-12, pp. 50-52, 82-83.

<sup>231</sup> CX-12, pp. 52-53.

<sup>232</sup> CX-12, pp. 54-57, 82.

<sup>233</sup> CX-12, p. 72.

<sup>234</sup> CX-12, pp 75-76.

<sup>235</sup> CX-12, pp. 77-79, 81.

<sup>236</sup> CX-11; EX-2; EX-9 (medical records).

reduce the pain so the patient's quality of life improves, or to identify the cause and send the patient for further care from a physician.<sup>237</sup>

His one and only appointment with Claimant was on 11 Nov 03, after Claimant's attorney, Rona Steele, made the appointment. He had an MRI report dated 28 May 03 and authored by Dr. Charles Aprill. He normally does not read films already reviewed by Dr. Aprill. He had Claimant fill out a Pain Assessment Tool. It is a multi-page form by that has questions about pain, the patient's response to pain, medications they have been on, how the injury occurred, if they had the pain problem before the injury, if they have an attorney, if are they involved in litigation or workers' compensation, what physical activities they can perform, and other similar questions. Claimant left his pain problem box blank on the Pain Assessment Tool. In response to the question, "Where is your pain located?" he said, "Lower back and left ankle." On a corresponding diagram<sup>238</sup> of a person, Claimant indicated his pain was located in the lower back, buttock, and left ankle regions.<sup>239</sup>

There was no clear indication on the pain drawing of a radicular component to Claimant's reported pain, but his notes show he had the impression that Claimant may have had pain going from his lower back down to his left ankle. A physical exam indicated that Claimant did not have a radicular pain component congruent with pain in the lower back, middle or lumbar spine. His impression after taking Claimant's history, a physical exam, and MRI review is that Claimant had disc protrusion and foraminal stenosis. He thought that because of the disc degeneration that Claimant had and the loss of spacing between L5 and S1 that Claimant may have facet pain. Claimant had muscle spasms as well, which usually goes right along with a patient with facet pain. His initial impression was that Claimant had a disc protrusion, but he thought Claimant had two separate pains in his lower back and in his ankle. The impression of foraminal stenosis was based on an objective diagnosis from the report of the MRI.<sup>240</sup>

He recommended Claimant have a further MRI and a lumbar facet block. Claimant did not complain of pain radiating through his buttocks down the leg to the ankle, but did complain of pain radiating from the middle of his spine out through the top of his buttocks.<sup>241</sup>

Claimant indicated on the Pain Assessment Tool document and in conversation that he was not taking any medications. Claimant may have run out of medication.

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<sup>237</sup> CX-11, pp. 7-9, 12, 14.

<sup>238</sup> EX-26.

<sup>239</sup> CX-11, pp. 10, 13-18; EX-9, p. 1.

<sup>240</sup> CX-11, pp. 18-22, 32-34, EX-9, p. 2.

<sup>241</sup> CX-11, pp. 23-24; EX-9, p. 2.

Carisoprodol is a muscle relaxant commonly known as Soma. He does not prescribe it because it is a sedative to the brain and much abused in society today. The normal maximum dosage for the 350 milligram tablet would be three a day. A 60-tablet quantity would cover a 20-day period.<sup>242</sup>

Claimant indicated his pain was related to an offshore accident in January 2003. He reported no prior accidents or injuries. Claimant's physical examination was negative for straight leg raising; indicating the absence of compression or irritation which would be aggravated by stretching of the nerve.<sup>243</sup>

Claimant reported stiffness of the ankle and occasional pins and needles sensation on both feet instead of just the left ankle. When a patient says he has pins and needles in both feet and has an MRI showing bilateral nerve compression, he can not definitely rule out the possibility of radicular pain based on nerve compression by disc. Dr. Aprill's MRI study indicated bilateral nerve compression in a diffused circumferential bulge, which could produce a pins and needles effect in both feet.<sup>244</sup>

Another part of his impression was that Claimant had lumbar spondylosis, which is disc degeneration. In L5-S1, the normal space between those two vertebrae has been lost. The normal pressure that the facet from L5 places on the facet of S1 has decreased the space between those two vertebrae and over time will result in an arthritic process where those facet joints become inflamed and cause more pain.<sup>245</sup>

He has no way to know whether the foraminal stenosis revealed in the 2003 MRI report pre-existed Claimant's reported accident of January 2003. If Claimant had degrading disc at L5-S1 prior to this accident and he was subjected to a fall, he would be more likely to have a disruption of a degraded disc and a protrusion out to one side than if he had a normal, uninjured disc. The same could result from a motor vehicle accident.<sup>246</sup>

He understood that Claimant twisted his ankle, fell, and injured his lower back while working on a boat.<sup>247</sup>

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<sup>242</sup> CX-11, pp. 24-28; EX-9, p. 3.

<sup>243</sup> CX-11, pp. 29-33.

<sup>244</sup> CX-11, pp. 34-35.

<sup>245</sup> CX-11, pp. 36-38.

<sup>246</sup> CX-11, pp. 38-41.

<sup>247</sup> CX-11, pp. 40-41.

If Claimant responded positively to the blocking of the lumbar facet median branch nerve and then his pain returned, the next plan would be to provide a radio signal to that lumbar facet median branch nerve that blocks the function of that nerve so it cannot send pain signals to the brain for anywhere from 8 to 18 months.<sup>248</sup>

A trans-foraminal epidural injection at the lumbosacral L5-S1 helps determine whether there is physical or mechanical pressure against the nerve. That may be an indication for a discectomy and perhaps a fusion.<sup>249</sup>

Claimant did not return to his office for any further treatment.<sup>250</sup>

If Claimant had received treatment for his low back injury for more than one year, he would need to know if the treatment was for a foraminal protrusion of disc material also. He would defer to the judgment of Claimant's prior treating doctor.<sup>251</sup>

Claimant signed a pain management contract that identifies expectations to the patient, allows the patient to understand what he will do for the patient as far as prescribing medication, and explains that he will follow state requirements to provide drug tests. The contract told him that he was not to use his medication other than the way it was prescribed and he was not to try to get it refilled before the day it was supposed to be refilled. It discussed sharing medication, protecting medication, using illegal substances, and discarding or changing medication. It told him that he cannot receive controlled medications from more than one physician at a time and that he needs to pick out one pharmacy to use and identify that pharmacy. He had the option to change the pharmacy, but he needed to notify the doctor before he did so. It told him he could not pick up the medications on the same day ordered.<sup>252</sup>

He prescribed Claimant Skelaxin, a muscle relaxer; Vioxx, an anti-inflammatory; and 60 tablets of Norco, a weak pain medicine consisting of hydrocodone and Tylenol mixed together. Claimant was supposed to take 4 to 6 Norco tablets per day, giving him a 10 to 15 day supply. He ordered one refill for Claimant on the original prescription. Claimant called in asking for another refill and he ordered a 90 tablet refill on 31 Dec 03. It was four pills a day, so it would have been roughly a 20 day supply. There was also a refill authorized on that order, which should have lasted about 25 days. He wrote another order for Claimant on 12 Feb 04 with a refill authorized and increased the quantity from 90 to 120. Claimant's

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<sup>248</sup> CX-11, pp. 41-42.

<sup>249</sup> CX-11, p. 42.

<sup>250</sup> CX-11, p. 46.

<sup>251</sup> CX-11, pp. 46-48.

<sup>252</sup> CX-11, pp. 49-51.

reorders and refills balanced out pretty close to when they should have. He had no contact at all with Claimant from April 2004 until June 2005. The last prescription that he wrote for Norco for Claimant was 14 Apr 04. He wrote a 90 tablet prescription for Lorcet with two refills for Claimant on 24 Jun 05.<sup>253</sup>

In December 2003, they were still awaiting approval for a procedure to be done. In June 2005, Claimant said that he needed to postpone his procedure for a few more weeks due to his girlfriend's surgery.<sup>254</sup>

If he determines a patient has received a controlled substance from another physician or selling or diverting their medication, he stops prescribing the controlled substance for that patient. He never refused to prescribe Norco for Claimant. After the April 2004 prescription, Claimant stopped requesting the medication until June 2005.<sup>255</sup>

If Claimant was not having back pain and was doing heavy manual work without physical problems or complaints of pain, but then injured his ankle so severely that he could not bear weight on it, and only days later noticed back pain, it is more likely than not that the fall caused his back pain.<sup>256</sup>

He does not necessarily need to spend a lot of time on the facts of how the injury occurred because he is not a lawyer and only needs to treat the pain. He only needs a description of the event in a way that could be related to the pain.<sup>257</sup>

Twisting a left ankle on a 4 x 4, falling, catching himself and lifting up back to his feet, only to let go and fall back down again could be consistent with a back injury. Not every person who goes through that is going to have a back injury, a disc herniation, or radicular pain. Nevertheless, Claimant's complaints of back pain are consistent with the type of injury he described.<sup>258</sup>

At Claimant's last visit, Dr. Hubbell recommended further medical treatment for Claimant's back injury.<sup>259</sup>

The findings on the MRI, and would be consistent with a herniated disc. The bulging, protruding disc at L5-S1 could cause a sensation of pain, but does not have to. There are people that have worse pictures that do not have any pain. A

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<sup>253</sup> CX-11, pp. 51-54.

<sup>254</sup> CX-11, pp. 54-55, 57.

<sup>255</sup> CX-11, pp. 55-56.

<sup>256</sup> CX-11, pp. 60-63.

<sup>257</sup> CX-11, pp. 63-64.

<sup>258</sup> CX-11, pp. 64-65.

<sup>259</sup> CX-11, p. 65.

person who has done heavy manual labor since they left school could have a certain amount of degeneration in the lower spine, but people do not necessarily get degeneration just because they work continually since their teenage years.<sup>260</sup>

The degeneration and the degradation noted to be moderate by Dr. Aprill was probably degenerated prior to January 2003. The fact that the nucleus has advanced and there is nuclear degradation probably means it was degenerated prior to the injury. The level of posterolateral disc protrusion would more likely have occurred with the fall based on the absence of any evidence that showed there was ever anything that occurred in the form of a posterolateral disc protrusion prior to 2003.<sup>261</sup>

The protrusion of the disc or the herniation of the disc described by Dr. Aprill could be pressing on the nerve roots and causing muscle spasm. Facet nerve blocks would indicate if the spasm was related to the facet.<sup>262</sup>

On 3 Dec 03 he found Claimant unable to work at his present job because it would exacerbate his pain. He probably would have approved Claimant for a sedentary position, at least to try 40 hours a week or alternating positions.<sup>263</sup>

The 30 Jun 05 MRI has evidence of a herniation at L4-5, which could be involved with the pain complaints. There is evidence that the herniation or the annulus at L5-S1 has become more than circumferential and has actually moved laterally more to the right, involving the right foramen potentially.<sup>264</sup>

Claimant is not a candidate for lumbar surgery until he has preliminary treatment that he needs to see if he can avoid surgery. Claimant would first need to undergo lumbar facet blocking, transforaminal steroid injections, and radio frequency. If Claimant received relief from these treatments, he would recommend a one week functional capacity evaluation before releasing Claimant to unrestricted work. If Claimant does not obtain relief for more than two weeks after the third treatment, then he would be sent to a surgeon for consideration of surgery to improve the pain.<sup>265</sup>

If Claimant was pain-free with no residuals from a prior injury, passed a physical exam by a company doctor, was able to work pain-free as a welder, and fell on the deck of the vessel offshore, it would be his opinion that the accident caused, aggravated, or exacerbated his lumbar condition.<sup>266</sup>

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<sup>260</sup> CX-11, p. 66.

<sup>261</sup> CX-11, pp. 66-67.

<sup>262</sup> CX-11, pp. 67-68.

<sup>263</sup> CX-11, pp. 68-69.

<sup>264</sup> CX-11, pp. 71-72.

<sup>265</sup> CX-11, pp. 72-80.

<sup>266</sup> CX-11, pp. 81-83.

***Dr. Michael Chambers testified at deposition in pertinent part that:***<sup>267</sup>

He is a general medicine physician at essentially a soft tissue clinic. One hundred percent of his business comes from attorneys representing injured individuals.<sup>268</sup>

He first saw Claimant on 26 Oct 04. He reviewed the medical records from Dr. Deiparine and Dr. Greenberg. Claimant informed Dr. Chambers that he had lower back pain, had an MRI, and was awaiting epidural steroid injections with another physician. The MRI showed back damage, but not that Claimant was an immediate candidate for surgery. It made sense to treat Claimant with epidural steroid injections, narcotics, and a barbiturate. Claimant did not complain of any ankle pain. Claimant provided a medical history. Claimant was asked about past accidents, but he did not reveal any sort of prior accident involving a problem with his low back.<sup>269</sup>

Claimant had ten office visits between October 2004 and his last visit on 14 Jul 05. Claimant consistently complained of back pain during those visits. As of 15 Jul 05, Claimant was still having pain concerns and the exam revealed tenderness that Dr. Chambers rated at a pain level of three out of five, with muscle spasms present. He also reviewed a second MRI report. On 15 Jul 05, he discharged Claimant from his care and referred Claimant to a neurologist for further medical treatment. Claimant had medical problems that required surgery, which he could not provide.<sup>270</sup>

He attributed Claimant's back injury to an accident Claimant reported having at work on 9 Jan 03. He opined that Claimant had one herniated disc, and multiple discs involved in the damage at other levels, and was unable to work. It is possible that if an employer was willing to accommodate Claimant's needs to alternate standing and sitting, and had a job Claimant was skilled to do, Claimant could have done a sedentary or light-duty job. He would not recommend that Claimant work while taking narcotic pain medication.<sup>271</sup>

Claimant signed a pain management contract providing that patients are not to receive narcotic medications from any other physician. Claimant was taking more narcotics through the summer of 2004. Claimant was not necessarily hurting more, but his body was acclimating to the medication. Claimant stabilized at a prescription rate of about 90 Lorcet and 90 Soma each month.<sup>272</sup>

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<sup>267</sup> CX-9.

<sup>268</sup> CX-9, pp. 6-8.

<sup>269</sup> CX-9, pp. 9-10, 20-22.

<sup>270</sup> CX-9, pp. 22-24, 62.

<sup>271</sup> CX-9, pp. 28, 33-34, 46-47, 53-57, 71, 73-74, 76-77.

<sup>272</sup> CX-9, pp. 65-68, 71-72.

***Dr. Lawrence Glorioso testified at deposition in pertinent part that:***<sup>273</sup>

He is board-certified in diagnostic and vascular interventional radiology. He interpreted Claimant's 30 Jun 05 MRI. There was a herniation of the L4-L5 intervertebral disc, a subligamentous herniation of a desiccated L5-S1 intervertebral disc, a local contained herniation of the L3-L4 disc eccentric toward the left side at the level of foramen, a rigid non-mobile Grade I anterolisthesis of L5 on S1 and a mild scoliosis in the spine.<sup>274</sup>

An anterolisthesis is the same thing as spondylolisthesis. It is more specific in that the abnormal positioning of spine is anterior. A patient can have a retrolisthesis or an anterolisthesis, whether it is anterior or posterior to the vertical segment below it. Claimant has an anterior shifting of the spine of L5 on S1. The L5 vertebra has shifted forward to the front on top of S1.<sup>275</sup>

He has also reviewed the MRI films from May 2003. It shows the anterolisthesis at L5-S1, but is much less apparent than it is on the 2005 MRI. Moreover, they were two different examinations. The May 2003 was a supine examination, which is notoriously poor for detecting anterolistheses and retrolistheses; whereas the 2005 MRI was a multi-positional examination.<sup>276</sup>

It appears that the degree of desiccation in L5-S1 has increased when the 2005 MRI is compared to the 2003 MRI. Desiccation can be from degeneration, trauma, or a prior infection of the disc as an end result of a discitis. There is also a subtle loss of disc space height of L5-S1 in 2005 as compared to 2003 or at least it is more apparent because the 2005 MRI was an upright weight bearing examination as opposed to the supported supine examination of 2003. A supine examination makes anterolistheses and retrolistheses less apparent.<sup>277</sup>

What he saw in the 2005 MRI as a posterior herniation of L4-5 with effacement of the thecal sac appears in the 2003 MRI as more of a bulge. That type of structural change might be related to the degree of herniation at L5-S1 or could be a function of the different MRI methods.<sup>278</sup>

There is not a significant change in the desiccation of the L4-L5 disc between 2003 and 2005. There are multiple morphologic factors that would accelerate desiccation at 5-1 relative to 4-5. First, there is an abnormal disc because there is

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<sup>273</sup> CX-13.

<sup>274</sup> CX-13, pp. 7-10.

<sup>275</sup> CX-13, pp. 11-13.

<sup>276</sup> CX-13, pp. 14-15.

<sup>277</sup> CX-13, pp. 16-22.

<sup>278</sup> CX-13, pp. 18-20.

a subligamentous herniation. Second, there are abnormal biomechanical stresses on that disc due to the sliding because of the anterolisthesis of L5 on S1. Those processes alone would accelerate the desiccation intervertebral disc at 5-1 greater than that at 4-5 or 3-4.<sup>279</sup>

He does not believe that Claimant has congenital anterolisthesis. The causes of congenital anterolisthesis are very, very rare. The most common is facet arthrosis, which appears in Claimant's 2003 MRI, although it is much less apparent than in the 2005 examination.<sup>280</sup>

Spondylolisthesis can be anterolisthesis, with the vertebral level above anterior, ventral to the vertebral level below; or a retrolisthesis where the vertebra is posterior or dorsal to the level below. Spondylolisthesis can be antero or retro. Anterolisthesis is only anterior and very rarely caused by a congenital defect. Spondylosis is mostly caused from trauma or stress during the teenage years. Spondylosis is the defect in the pars interarticularis.<sup>281</sup>

He does not see Spondylosis in the 2003 MRI. A subtle Spondylosis can be easily missed at MRI because there are not a large number of detailed segments. However, it is very easily shown with plain films. He does not see anterolisthesis in either 2003 or 2005 films.<sup>282</sup>

There can be anterolisthesis without Spondylosis and spondylolisthesis posterior without Spondylosis. The most common cause of anterolisthesis is facet arthrosis. Facet arthrosis is a condition that could arise from a back injury such as one falling on one's buttocks. It could also arise from degeneration or infection.<sup>283</sup>

There is a retaining ligament called the posterior or longitudinal ligament that runs in a cephalad/caudad direction. Subligamentous herniation means the annulus fibrosis of the disc is torn, but the posterior longitudinal ligament is intact. It is not penetrated in that the disc material is deep to the posterior longitudinal ligament.<sup>284</sup>

It appears that the L5-S1 disc is pressing against the L5 nerve root. He did not observe that on the 2003 MRI.<sup>285</sup>

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<sup>279</sup> CX-13, pp. 21-23.

<sup>280</sup> CX-13, pp. 23-24.

<sup>281</sup> CX-13, pp. 24-26.

<sup>282</sup> CX-13, p. 26-27.

<sup>283</sup> CX-13, p. 27.

<sup>284</sup> CX-13, pp. 27-28.

<sup>285</sup> CX-13, p. 28.

Claimant also has lumbar lordosis. The most common etiology of lumbar lordosis is back pain and muscle spasm. As a protective mechanism for pain of the spine, the muscles go into spasms. As the muscles go into spasm, they hold the spine tight and rigid which can cause a loss of lordosis. The loss over time could be contributed to what is occurring in Claimant's spine at L5-S1, L4-5 level or it could be a function of the type MRI.<sup>286</sup>

He cannot tell whether the herniation at L5-S1 was caused by a fall for which Claimant developed pain several days later. He can only say he sees an abnormality in 2005 that is not apparent on Claimant's 2003 examination.<sup>287</sup>

The L5-S1 herniation is more apparent in 2005 than in 2003. He cannot say there was a L4-5 herniation in 2003, although it was an abnormal disc in 2003.<sup>288</sup>

The worsening of the L5-S1 disc observed in the 2005 MRI could be consistent with an injury in January 2003 worsening his condition.<sup>289</sup>

He cannot tell whether Claimant sustained any type of traumatic spondylolisthesis or L5-S1 anterolisthesis. The anterolisthesis is more apparent in 2005 than in 2003.<sup>290</sup>

A Grade I is anything from the subtlest anterolisthesis to one-third of the vertebral body. Grade II is from one-third to two-thirds slippage. Grade III is greater than two-thirds slippage. Grade IV is spondyloptosis, where the vertebra falls off the end.<sup>291</sup>

It would be unlikely for an adult to fracture the pars interarticularis by falling a short distance onto their buttocks. Most spondylolysis occur from prepubescent trauma.<sup>292</sup>

***Dr. Joseph Mogan testified at deposition in pertinent part that:***<sup>293</sup>

He currently is on the staff at two inpatient rehabilitation hospitals. He is board certified in the field of physical medicine and rehabilitation. He is also board certified in pain management. His goal is to improve patient function and minimize pain for improvement of quality of life and activities of daily living. His

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<sup>286</sup> CX-13, pp. 33-35.

<sup>287</sup> CX-13, pp. 38-39.

<sup>288</sup> CX-13, pp. 39-40.

<sup>289</sup> CX-13, p. 40.

<sup>290</sup> CX-13, pp. 41-42.

<sup>291</sup> CX-13, pp. 44-45.

<sup>292</sup> CX-13, pp. 47-49.

<sup>293</sup> EX-40; CX-34.

office works closely with the DEA and turns over any patient that is found to be doctor shopping. He asks all of his patients whether they have a prior felony conviction and he turns over his list of patients to the DEA to see if any of them are on doctor shopping lists. If they have a felony conviction he tends not to accept them as patients, but it is his discretion. He will not see patients that have a drug conviction or have been seen in a methadone clinic for addiction. Not a single patient from any of the three clinics he works with has been on the DEA list of doctor shoppers or most wanted patients. If he discharges a patient for wrongdoing he turns the chart in to the appropriate authorities. He also knows which pharmacies carry Schedule 2 drugs and he can call to see if a patient is filling their medications at different pharmacies. His office has weeded out a lot of bad patients and the DEA agent says they are the best in the state at what they do. His office also subscribes to a service that informs them if a patient is filling their medications with their insurance cards from him or from another doctor. If the medication is paid for in cash, there is no way to check for multiple prescriptions.<sup>294</sup>

He first saw Claimant on 26 Sep 05. Claimant informed Dr. Mogan that he was treating with Dr. Chivarton and that the doctor prescribed him Lorcet and Soma. Claimant complained of aching, burning, pins and needles, stabbing in his back, numbness with pins and needles down his left leg. Claimant signed a pain contract on 06 Sep 05 and signed a HIPA page for health information and privacy on 26 Sep 05. Dr. Mogan has patients come in three days before their first appointment to complete paperwork. Claimant also paid for his first office visit when he came in on 23 Sep 06. A Pain Management Contract is an agreement by the patient that he will not get his controlled substances from any other doctor. He may obtain medication from his psychiatrist, but only if the pain manager is not already prescribing the medication. Even if a patient goes to the dentist, the pain management doctor monitors and prescribes the narcotics for the dental procedure. However, since he can only follow-up with patients about once a month, he does not strictly enforce if a patient sees a dentist and gets a Schedule 3 pain medication. Regardless, the patient must tell him if he got a prescription elsewhere. He makes sure his patients know they must notify him. Patients may also go to an ER and get a shot of something strong if his pain medicines are not enough.<sup>295</sup>

Dr. Mogan might prescribe Ambien or Klonopin for sleep and allow his patient to get his Xanax from his psychiatrist, as long as he knows about it. When Claimant started treating with Dr. Mogan, he was prescribed Hydrocodone and Tylenol and Soma. However, the dosage was not enough to control his pain. Dr. Mogan maintained Claimant on Soma and Lortab and also gave him Klonopin for insomnia and anxiety. Soma is not considered a narcotic or even a controlled

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<sup>294</sup> EX-40, pp. 7-25.

<sup>295</sup> EX-40, pp. 25-33, 123-128.

substance, so it is not part of the pain management agreement. However, it can provide a euphoric feeling if a patient takes more than required and when mixed with Lortab and Xanax. One reason for the Klonopin was post-traumatic stress disorder from hurricane Katrina, but the main reason he prescribed the Klonopin was because Claimant had insomnia due to his pain. He then started Claimant on Xanax instead of the Klonopin. Dr. Mogan only asks for pharmacy profiles if he suspects a patient of doctor shopping. If he suspects a patient of doctor shopping, sometimes the DEA wants him to continue treating them so the DEA can follow the patient.<sup>296</sup>

Dr. Mogan gives the DEA a periodic list of patients with their date of birth, social security number, and driver's license number so they can check their records to see if those patients have any problem drug history. The DEA did a search around January 2006 and found all of their patients were clean, including Claimant. At the time Claimant started treating with Dr. Mogan, the doctor was aware that Claimant was prescribed Hydrocodone and Soma by Dr. Chambers every two weeks and also had two visits with Dr. Chivarton.<sup>297</sup>

Dr. Chambers, a staff physician at a soft tissue injury clinic and a board certified anesthesiologist, also treated Claimant prior to Dr. Mogan. Dr. Chambers put Claimant on Elavil. Dr. Mogan did not confer with Dr. Chambers regarding Claimant's pain management treatment. He did not contact any of Claimant's physicians; he just read their reports, including Dr. Aprill's interpretation of the MRI. He considers Dr. Aprill the "gold standard for interpreting MRIs." Claimant has progressive weakness of his left gastrosoleus complex and atrophy of the gastrosoleus muscles. If someone has progressive weakness or numbness, then they are a surgical candidate for decompression. Therefore, he believes Claimant is a surgical candidate. Claimant stated he was interested in both conservative treatment and surgery. Surgery, along with other conservative treatments, can help prevent further neurological deficit. Even though Dr. Mogan tends to be conservative when treating his patients, he agrees with Dr. Vogel's opinion that Claimant needed surgery and the only reason Claimant has not had it yet is financial reasons. Dr. Mogan's practice is conservative management. He does not perform surgeries.<sup>298</sup>

Physical examination revealed atrophy in Claimant's calf. Claimant walked with a limp and has posture pain when sitting. He also had pain with certain movements throughout the exam. Dr. Mogan noted a positive straight left leg raise. He complained of pain radiating down his leg all the way to his foot. He also tried to improve Claimant's sensory and motor deficits with the McKenzie treatment, by centralizing the nuclear material back to the center of the disc before the

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<sup>296</sup> EX-40, pp. 33-42, 142-144.

<sup>297</sup> EX-40, pp. 128-131.

<sup>298</sup> EX-40, pp. 42-49.

degenerative process sets in. He believes he got good centralization and Claimant was responding to the treatment. Claimant still had intermittent numbness and atrophy from some prior motor damage. Claimant performs the exercises at home on his own. It is usually a repetitive end range movements in the direction of extension. Claimant reached a point where he plateaued and they stopped the McKenzie exercises once they stopped working. Dr. Mogan then performed trigger point injections and saw Claimant's mobility improve with extension. Dr. Mogan believes Claimant was closing down on his facet joints which were also irritated and painful, increasing his radicular symptoms. He then explained to Claimant the necessity for decompressive techniques, such as Vax-D, however, the cost and distance to get the treatment was prohibitive. He also told Claimant that epidural steroid injections could help preserve the nerve root and is a lot cheaper than surgery. He referred Claimant to Dr. Aprill for the injections. Claimant treated with Dr. Mogan on a monthly basis.<sup>299</sup>

A review of Folse Pharmacy records show that Claimant filled medication from Dr. Chambers on 13 Jul 05, the same day he wrote prescriptions for Hydrocodone and Carisoprodol. This conflicts with Claimant's statement to Dr. Chivarton that he was released by Dr. Chambers 27 Jun 05 and had no medications since released, other than his girlfriend's medication. Claimant should have had enough medication from Dr. Chambers to last him through 18 Jul 05. Claimant returned to Dr. Chambers on 13 Jul 05 and got a refill on all of his medications. Claimant first saw Dr. Chivarton on 09 Aug 05. This is almost one month after he saw Dr. Chambers and if he did not fill Dr. Chivarton's prescription then he did not violate the pain management contract. So long as Claimant is filling a prescription one month after his last one when he changes doctors, he is not breaking the pain contract by filling it three days early. Everything was timed just right. Even Dr. Chambers saw him in less than 30 day intervals. There can be a three to five day buffer. Elavil is not a controlled substance so it is okay if he refilled that prescription early. Besides Claimant said that Elavil was not working for him and he probably just filled it late because he was running low on his medications and that was the only thing he could think to do to help himself.<sup>300</sup>

It was not necessarily a misrepresentation to Dr. Chivarton when Claimant said he did not have any medication since 27 Jun 05. It could have been a mistake by the doctor or Claimant could have just given wrong information. Dr. Mogan cannot assume the mistake was Claimant's. If Claimant made the statement that he "had no medication since release, other than wife's," it is a misrepresentation and a violation of the pain management contract because (1) he took someone else's medications; (2) states he was released three weeks before he was actually released; and (3) he was released with medications and said he was not. Claimant also filled prescriptions for Hydrocodone, Carisoprodol, and Mirtazapine on 24

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<sup>299</sup> EX-40, pp. 49-58, 131-135.

<sup>300</sup> EX-40, pp. 59-68.

Aug 05, fifteen days after his first visit with Dr. Chivarton. Upon review of the record, Dr. Mogan understood that Claimant is keeping with his pain contract with Dr. Chambers even though Dr. Chivarton's notes reflect otherwise. Claimant is filling his prescriptions on schedule.<sup>301</sup>

The fact that Claimant filled Soma prescriptions within two weeks of each other is okay because Soma is not a controlled substance that is regulated by pain management contracts. Claimant filled the controlled substances only as regulated by the pain management contract. However, Dr. Chivarton's pain management contract includes muscle relaxers, which Soma falls under. As such, although Claimant's filling his Soma prescriptions early and by two different doctors is not a violation of the law, it may be violation of Dr. Chivarton's pain management contract. Claimant was also being weaned off the Lorcets by Dr. Chambers at the time he was changing doctors and Claimant have decided to take more Soma than prescribed because he was suffering from a lot of spasms. He also took the Elavil which is good for neuropathic pain, anxiety, muscle spasms and insomnia. Dr. Mogan cannot do anything more than speculate.<sup>302</sup>

The pain management contract attempts to prevent diversion (the procurement of controlled substances with intent to distribute for profit or non-profit). Claimant filled a prescription for Hydrocodone (42) and Soma (28) on 20 Sep 05, one-third less than he was normally prescribed. Claimant did not have enough medication to last him the rest of the month. He first treated with Dr. Mogan on 26 Sep 05 and Dr. Mogan prescribed Hydrocodone, Soma, and Klonopin. This does not violate the pain management contract because Dr. Mogan timed it for "roughly a week later." Dr. Mogan only prescribed him 75 pills because Claimant should have had some left in his prior prescription.

Although the pharmacy records reflect that Claimant next refill was on 07 Oct 05, Claimant returned on 07 Oct 05 stating that he did not tolerate the Klonopin and his pain was not well-controlled on the current dosage of Lortab. This reflects that he in fact filled the 26 Sep 05 prescriptions. It is possible that Claimant filled the prescriptions elsewhere. Because Claimant did not tolerate the Klonopin, Dr. Mogan changed the prescription to Alprazolam. Claimant filled his prescriptions for Alprazolam, Hydrocodone, and Soma on 07 Oct 05. Claimant remained on Dr. Mogan's pain management contract from October 2005 through February 2006.<sup>303</sup>

If Claimant received a prescription from Dr. Vogel for Darvocet, Soma, and Limbitrol on 09 Jan 06, it overlaps with a time period that Claimant is under pain management care with Dr. Mogan. However, Dr. Mogan recalled that Claimant informed him that Dr. Vogel prescribed those medications even if it is not in the

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<sup>301</sup> EX-40, pp. 68-73.

<sup>302</sup> EX-40, pp. 73-79.

<sup>303</sup> EX-40, pp. 79-88.

record. Claimant indicated to Dr. Mogan that he did not fill those prescriptions. Had Claimant filled Dr. Vogel's prescriptions, Dr. Mogan would have notified his business partner and informed him that Claimant was in violation of the pain contract. It is the doctor's discretion to discharge a patient if they violate a pain contract. It is not a violation of the pain management contract to receive a prescription from another doctor; it is a violation to fill that prescription. If Claimant filled the prescription for Darvocet and Limbitrol it would be a violation of the contract. Claimant filled out a "pain faces scale" on 27 Jan 06, indicating that a physician has not started him on any new medication. However, if Claimant did not fill the prescriptions from Dr. Vogel, then he did not start new medication.<sup>304</sup>

When Claimant returned on 24 Feb 06, Dr. Mogan referred Claimant to Dr. Aprill and two surgeons who accept Medicaid for back surgery. Dr. Mogan had no record of whether Claimant saw Dr. Aprill in 2005 or 2006. There was no discussion of discontinuing treatment with Claimant on 24 Feb 06. Claimant needs continued treatment, including surgery, and suffers from chronic pain. Claimant filled a prescription for Xanax, Soma, and Lortab on 24 Feb 06 and refilled them on 09 Mar 06 from Dr. Mogan. Claimant saw Dr. Manale on 24 Mar 06, who also provided Claimant with Soma, Lortab, and Xanax, in the same quantities as Dr. Mogan prescribed. A review of the pharmacy records from both Fred's and Drennan's Pharmacies reflects that Claimant would have been very low or out of medication on 24 Mar 06. If Claimant told Dr. Manale that he was no longer treating with his pain management doctor it would not be a violation of Dr. Mogan's pain management contract because even if a patient does not formally tell Dr. Mogan that it is his last office visit, he can still transfer to another doctor. Claimant did not go to another doctor until his medications ran out. Even though Dr. Manale was an IME, it was okay for Claimant to get a prescription from him until he found a new pain management doctor. Claimant did not go back to Dr. Mogan and try to get refills. Therefore, there is no violation of the pain management contract. Claimant just did not tell him it was his last visit even though he called Dr. Mogan on 25 Mar 06 and said he was going out of town and could not make his scheduled appointment. Patients self discharge all the time.<sup>305</sup>

Claimant filled a prescription by Dr. Deiparine for 60 Hydrocodone on 11 Jun 04 at Folse. Walgreens dispensed another prescription for 60 Hydrocodone on 29 Jun 04 which was also prescribed by Dr. Deiparine. The prescriptions should last one month and there is only two weeks between. It is a red flag for a patient to go to two different pharmacies 18 days apart for refills of the same prescription. However, both of the prescriptions were from Dr. Deiparine and Claimant may have been holding the other prescription back if he did not need it as much and then decided to fill it. It could also be that Claimant needed more than two pills

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<sup>304</sup> EX-40, pp. 88-99.

<sup>305</sup> EX-40, pp. 98-118, 154.

per day and Dr. Deiparine issued another prescription to make up the difference. Dr. Mogan did not know how often Claimant treated with Dr. Deiparine and it could very well have been every two weeks. If Claimant did not see Dr. Deiparine on 29 Jun 04, then it indicates that Dr. Deiparine gave Claimant two separate prescriptions. It is not likely a refill because of the two separate pharmacies. It could also mean that Dr. Deiparine called it into the pharmacy himself. It could also mean that the patient forged the script and took it to another pharmacy, but that is only speculation. However, the record reflects that Dr. Deiparine treated Claimant on 29 Jun 04 and prescribed medication.<sup>306</sup>

Dr. Mogan noted on several occasions that he noticed atrophy in Claimant's left lower extremity. Atrophy does not disappear and then reappear. Dr. Mogan agrees with Dr. Vogel's assessment that Claimant needs surgery, specifically a fusion. "Anytime someone has progressive neurological deficit that causes weakness and/or atrophy, or loss of reflexes, they are getting motor-neuro destruction, and that's an absolute indication for surgery in my opinion." Conservative treatment might relieve irritation from chemical injury and buy Claimant some time, but the effacement will require further epidurals until they stop working, if they work at all. Dr. Mogan has never seen the amount of atrophy Claimant has reversed, but surgery could help prevent further progressive atrophy. The nerve root effacement that is pressed upon by the herniated disc on the nerve root is causing the need for surgery in light of the atrophy.<sup>307</sup>

Dr. Mogan would take Claimant back as a patient because he did not violate his pain contract. A review of the pharmacy records reflects no inappropriate medications in light of Claimant's physical condition. In addition, a review of the record shows that Claimant did not always fill the prescriptions at the time prescribed and filled them when he needed them. Claimant is right on schedule with his medications. The record even shows a two week period where Claimant was without his Hydrocodone. If it looks like he filled it too many times down the line, it may be because he had a little bit left over at the time he was transitioning from Dr. Chambers to Dr. Chivarton and could not afford to have it filled. Claimant took his medications as prescribed.<sup>308</sup>

Claimant told Dr. Mogan that he fractured his left ankle during a work accident and that his low back was not bothering him after the accident. Claimant did not tell him that he fell on his coccyx (the bottom tip of the spine/tailbone); Dr. Mogan learned that from reading Dr. Vogel's deposition. Dr. Mogan relates Claimant's current problems with his lower back to the 2003 work injury.<sup>309</sup>

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<sup>306</sup> EX-40, pp. 159-183.

<sup>307</sup> EX-40, pp. 146-152.

<sup>308</sup> EX-40, pp. 152-169.

<sup>309</sup> EX-40, pp. 169-173.

***Dr. Mortezia Shamsnia testified at deposition in pertinent part that:***<sup>310</sup>

He is an adult board certified physician and also practices adult and pediatric neurology. He has been on the Tulane faculty since 1987 and is currently an associate professor of neurology. He directs EMG labs and teaches general neurology, as well as the subspecialty neurophysiology. He also has a private practice where he sees patients independent of his teaching. He has private practices in multiple locations. Claimant's attorney referred him to Dr. Shamsnia for a neurological evaluation and an EMG and nerve conduction study. Dr. Shamsnia did not speak with Claimant's attorney prior to evaluating Claimant; he just got a letter of referral. He does not automatically perform EMG and nerve conduction studies on every patient with back pain, but most of the time once a patient has come to Dr. Shamsnia, he has already seen a lot of doctors and either has chronic back pain or failed back syndrome. He deals mostly with complicated cases. He would not order an EMG or nerve conduction study before conducting a neurological evaluation on his patients. Dr. Shamsnia obtained a history from Claimant and also reviewed Claimant's medical records and diagnostic reports. He did not review any x-rays and believes he only reviewed a lumbosacral MRI. Claimant brought the MRI films to his appointment and Dr. Shamsnia did not know the date of the MRI. He has but did not read Dr. Vogel's deposition.<sup>311</sup>

Dr. Shamsnia performed a neurological evaluation and an EMG on 22 Mar 06. Claimant complained of lower back pain and radiating pains to his left leg with associated numbness. Claimant filled out a "review of the systems" and his main complaints included memory problems, sleep problems, anxiety, tremor, fatigue, tiredness, and weakness. Claimant informed Dr. Shamsnia that he had a prior car accident about five years earlier and had fully recovered from that accident. Physical examination revealed muscle spasms in Claimant's lower back and loss of his spinal curvature in the lumbosacral area. These are objective findings. Claimant also had difficulty bending forward and backward. There were no other significant neurological findings. A review of the MRI revealed Claimant has disc herniation at L4-L5 and L5-S1.<sup>312</sup>

He performed conducted the nerve conduction studies and the needle exam upon Claimant. Claimant's right side was completely normal, but the left peroneal nerve had a significant drop in the amplitude. Amplitude is the height of a response. Nerves are like electrical wires. When a nerve is shocked, the axons are activated and electricity goes through it and the muscle response is recorded. The peroneal nerve is the nerve that ends up in the foot muscle. Claimant had a 50 – 70 percent drop in the amplitude of the response in the left compared to the right. There is significant asymmetry between the sides. That implies that the peroneal

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<sup>310</sup> CX-33.

<sup>311</sup> CX-33, pp. 5-20, 65-71, 74-76.

<sup>312</sup> CX-33, pp. 20-23, 71-73.

nerve, which is part of the sciatic nerve, has L5-S1 and some L4 nerves on it. In a sense, the nerve is not functioning. He diagnosed Claimant with left peroneal nerve neuropathy based on the nerve conduction studies. The abnormalities could be consistent with the MRI where the disc was pressing on the nerve. One of the causations for low amplitude peroneal nerve/peroneal neuropathy is sciatic nerve injury – i.e. damage to the nerves to the leg or back. So either or both nerve roots could be causing the nerve to be abnormal. The F-wave also reflected that Claimant's right side responds quicker and is normal. The left side is delayed, which means the peroneal nerve is sick. The asymmetry in the F-wave would not be significant if that was the only abnormality present.<sup>313</sup>

Dr. Shamsnia also performed a needle exam (EMG). The needle is inserted into the muscle to determine muscle functions. The EMG was abnormal, concentrated more on the left L5-S1 innervated muscles. The medial gastrocnemius has increased insertional activity. The peroneal nerve does not go through the medial gastrocnemius. The needle records electrical discharges in the muscle. It takes a couple of years of training to learn the techniques for determining increased activity. Dr. Shamsnia has performed tens of thousands EMG studies and is board certified in electromyography. Claimant's nerves that innervates medial gastrocnemius muscle (inner part of the calf muscle) are sending abnormal signals. The posterior tibial was also abnormal and Dr. Shamsnia found a decrease in the motor unit potentials. There is nerve damage and Claimant's muscle is not capable of generating all these activities or there is some atrophy inside the muscle. There was increased activity next to the lumbosacral paraspinal.<sup>314</sup>

Polyphasic units means the abnormalities did not occur a few weeks ago. Every time the brain sends a signal, muscle fibers under the control of the nerve get activated – called motor unit. If there is damage to the nerve, the nerve will try to come back and repair itself/reinnervate. Every time a patient activates the muscles, it activates a bunch of muscles, a unit which has more phases. Usually if there are more than 3 or 4 phases then it is considered abnormal. Dr. Shamsnia records the muscles, but it tells him about the nerve. Polyphasic means that there was a nerve injury and the injury did not occur within the last three months. The body tried to heal itself. Even if Claimant has the discectomy, fusion, and foraminotomy and the herniated disc pressing on the nerve is removed, in all likelihood he will still have permanent nerve damage. Surgery may eliminate a compressive part, but if the damage has already occurred to the nerve surgery does not fix it, the body has to fix it. There is no procedure available to fix a nerve.<sup>315</sup>

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<sup>313</sup> CX-33, pp. 23-34, 110-111; CX-29, p. 3.

<sup>314</sup> CX-33, pp. 34-42, 97-101, 104-106; CX-29, p. 3.

<sup>315</sup> CX-33, pp. 42-48.

When a nerve injury occurs, a patient has one to two years to heal and recover. That is why it is so important to get the surgeries done in an appropriate time because once that window passes, even with surgery, the nerve injury will remain. Claimant did not have his nerve test conducted until three years after his injury. In Claimant's case, Dr. Shamsnia believes the nerve damage is permanent.<sup>316</sup>

It is Dr. Shamsnia's impression that Claimant's left peroneal nerve is abnormal and he has left L5-S1 radiculopathies. He attributed the abnormal findings to the herniated disc at L4-5 and L5-S1. As to Dr. Katz's problem that Dr. Shamsnia failed to isolate the nerve root, Dr. Shamsnia responded hardly any muscle has a nerve coming from one root so there is an abnormality with the medial muscle any of the nerve roots can be the problem or a combination of all three. The posterior tibia muscle is abnormal and is innervated mainly by L5 and some S1 nerve roots, which means that either root or a combination of both caused the problem with the muscle. It is the job of the treating physician to look at other diagnostic tools to decide the most common area in the spine causing a patient's symptoms. With Claimant, it is probably a combination of both. Claimant has two disc herniations – L4-L5 and L5-S1. Dr. Shamsnia believes the most dominant nerve in Claimant is S1 and then to some degree L5. In Claimant's case, he has an indication that one or two, L5 or S1 or both, are abnormal and that is what happens to a lot in people who have surgery. There is no way to definitively state whether it is L5 or S1.<sup>317</sup>

Although Drs. Glorioso, Katz, Manale, and Vogel opined that Claimant has Grade I spondylolisthesis, Dr. Shamsnia believes the problems are caused by a herniated disc pressing on the nerve root. Spondylosis is degeneration of the spine and spondylolisthesis is a little movement of the spine. Grade one spondylolisthesis probably could not have generated the results achieved by the nerve conduction study. Dr. Shamsnia points out that Dr. Glorioso report reflects that there is some impingement on the left L5-S1 nerve root at the L5-S1 disc pathology. Dr. Shamsnia opined that Grade I is very mild and not significant, but can contribute to the overall problem. Claimant has an obvious disc herniation in two levels. To look for discogenic pain, a discogram would be useful. However, in Claimant's case, he does not know what a discogram would add. He already knows that the discogram will be positive in both L4-L5 and L5-S1. Dr. Shamsnia would operate on L5-S1 first based on the MRIs and EMG findings. It would be better to operate on both levels though because Claimant will still have symptoms if only operated on one level. In the field of electromyography, another board certified neurologist could not look at the same test and conclude that they were normal because it is too obvious. However, the neurologist can repeat the study if they want even though it is a painful test.<sup>318</sup>

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<sup>316</sup> CX-33, pp. 48-49.

<sup>317</sup> CX-33, pp. 49-56, 97; CX-29, p. 3.

<sup>318</sup> CX-33, pp. 56-60.

Claimant may still benefit from surgery because there is always an “if” question. If there is a disc pressing on the nerve and applying ongoing pressure, that disc should be removed and give the patient a chance to heal. Although Claimant’s condition is permanent, it does not mean that he will not improve. If there is obvious pressure of the disc on the nerve, then it needs to be removed. He based his opinion on his years of experience of seeing these kinds of patients. Claimant will not fully recover from surgery, but it will improve his symptoms. He would know the extent of the residual nerve damage about six months to one year after surgery. He would re-evaluate Claimant six months after the surgery and redo the nerve test if he continues to be symptomatic.<sup>319</sup>

If there is pressure on the nerve by the disc, then Claimant’s condition will worsen without surgery. Dr. Shamsnia believes there is pressure at the L5-S1 disc. Based on the history Claimant provided and a review of the medical records, it is Dr. Shamsnia’s opinion that the left peroneal neuropathy and left L5-S1 radiculopathy were caused by his work accident on 09 Jan 03. However, when rendering his opinion on causation, he relied solely on the history Claimant recited to him. Claimant filled out an account of his accident and stated that he backed up to get away from a load and stepped on a 4 x 4 and twisted his ankle. Based on that statement alone, the accident could not have caused Claimant’s herniated disc.<sup>320</sup>

Dr. Shamsnia would not consider surgery until conservative treatment is exhausted because sometimes patients get better and respond to conservative treatment. It all depends on the underlying pathologies. Physical therapy is always good for anyone with back injuries. There is some disagreement as to epidural steroid injections. Neurologists are normally not keen on epidural injections. Even when injections are given, the effect is temporary and it helps in acute phases. Epidural injections have limited use. He prescribed Claimant Soma and Lortab. Claimant did not tell Dr. Shamsnia that he had a treating pain management physician and was receiving narcotic pain medication from other physicians. He could not recall whether Claimant told him he was not receiving other pain medication. He does not have his patients sign pain management contracts. If Claimant treated with him and Dr. Shamsnia learned he was obtaining pain medication from another physician, he would refuse to write any other prescriptions because it usually means the patient is abusing his medication.<sup>321</sup>

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<sup>319</sup> CX-33, pp. 60-61.

<sup>320</sup> CX-33, pp. 61-65 100-105.

<sup>321</sup> CX-33, pp. 110-118.

If a neurosurgeon recommended surgery, then Dr. Shamsnia would agree with the neurosurgeon. If Claimant is a smoker, then his chances for success from the recommended surgery would decrease. He should stop smoking a few months before the surgery is performed because smoking lowers the chances for healing. He would not recommend surgery solely for a Grade I spondylolisthesis.<sup>322</sup>

***Dr. Bernard Manale testified at trial in pertinent part that:***<sup>323</sup>

He is a board certified orthopedic surgeon. He last performed orthopedic surgery four years ago. He was not in an active medical practice for the first two years because of heart problems. He started to come back, but that was interrupted by Hurricane Katrina. He does not have any current plans to resume his surgical practice. He performed an independent medical examination on Claimant on 24 Mar 06<sup>324</sup> per the request of Claimant's attorney. He is not Claimant's treating physician and merely assessed Claimant's medical condition and issued an opinion to counsel. Claimant's chief complaints were related to his low back pain and left lower extremity pain. Claimant described the accident and said the crane picked him up, he fell onto his back and initially hurt his left ankle. Claimant tried to go back to work, but after one day he quit because of the pain.<sup>325</sup>

Claimant filled out a history questionnaire prior to Dr. Manale's evaluation. Claimant noted that he was injured while unloading a boat. He wrote that he twisted his "ankel," the crane lifted him up and he fell to the deck, hurting his back. He further reported that the pain started about two to three days after his accident. He informed Dr. Manale that he was in a motor vehicle accident a long time ago.<sup>326</sup>

Dr. Manale only saw Claimant one time, but Claimant told him that the pain in his back and leg has worsened. He reviewed Claimant's EMG and nerve conduction study from 22 Mar 06 which revealed left peroneal neuropathy and left L5-S1 radiculopathy. He also reviewed the 2003 and 2005 MRI films. Dr. Manale believed the 2003 MRI revealed a slipped vertebra (even though not mentioned by radiologist). The 2005 MRI also showed the slipped vertebra. In general, Claimant has a ruptured disc at L5-S1 that presses on the nerves at the S1 nerve root on the left. Claimant also has degenerative disc disease at that level. Dr. Manale took x-rays which showed the slipped vertebra and Claimant has a defect in the pars interior arthritis which is the most common form of spondylolisthesis.

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<sup>322</sup> CX-33, pp. 118-125.

<sup>323</sup> Tr. 38-89; CX-28.

<sup>324</sup> EX-31.

<sup>325</sup> Tr. 38-41, 62; CX-28, p. 1.

<sup>326</sup> EX-32.

Claimant had a complex pathology consisting of degenerative disc, narrowing, rupture, bony defects, and a slipped vertebra.<sup>327</sup>

Dr. Manale believes Claimant's spondylolisthesis is acquired, not congenital because the type Claimant has is very rarely seen in a newborn. Congenital means you are born with it. Claimant does not have any other spondylolisthesis. He believes the degree of spondylolisthesis was the same on 28 May 03 as it was on 30 Jun 05. However, the MRI does not show early or very minimal first degree spondylolisthesis. He saw both MRI films at the same time. He also had x-rays which showed the defects. Therefore, part of his determination was hindsight since he already knew what he was looking for.<sup>328</sup>

He conducted a physical examination of Claimant on 24 Mar 06. He observed Claimant walked stiffly and with some pain, favoring his left lower leg. Claimant also had tenderness in his back muscles and marked tenderness along the sciatic nerve of his buttock where the nerve leaves the pelvis and goes down behind the left knee. He had intermittent reduced motion with spasm when he bent from side to side. He had 50 percent normal motion. With "[s]ome patients with spondylolisthesis, when the vertebrae shifts, you can feel a step." Dr. Manale did not feel a step with Claimant, but he had very slight first degree spondylolisthesis. The physical examination also revealed that Claimant's left buttock was smaller than his right, which is muscle atrophy. He also measured the circumference of Claimant's calves and found the left calf was one inch less in circumference than the right. In addition, some of the muscles that pull up his great toe seemed to be weaker on the left than on the right. He can move his toe, but it does not have the normal power. Claimant had decreased sensation in two of the dermatomes – L5 dermatome which is on the inside and S1 dermatome on the outside of his leg. As far as Dr. Manale could tell, Claimant's ankle was fine with no deformity or residual.<sup>329</sup>

Claimant had a negative straight leg raising test. It is not significant because sometimes the test is negative when the nerve has permanent damage and does not react. Claimant still had other findings compatible with radiculitis. There were more findings to justify his diagnosis than to negate it. Dr. Manale did not perform a stretch test for sciatica during the evaluation and did not know why he did not. Since he did not have an x-ray or MRI from prior to 09 Jan 03, he could not state whether the spondylolisthesis was present prior to Claimant's work injury. Based on the natural history of Claimant's type of spondylolisthesis, chances are that Claimant had pre-existing spondylolisthesis, but did not have any trauma or do anything that started his symptoms until his work injury, especially since he did not have that bad of a fall. In addition, if it was fresh

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<sup>327</sup> Tr. 41-43; CX-28, pp. 1, 3.

<sup>328</sup> Tr. 43-45.

<sup>329</sup> Tr. 45-47; CX-29, pp. 2-3.

spondylolisthesis Claimant would have had a fracture of the pars, which he did not. His disc space was also narrowed and that takes time to occur. As such, Dr. Manale opined that Claimant's spondylolisthesis is pre-existing.<sup>330</sup>

Although Dr. Manale believes Claimant's spondylolisthesis is pre-existing, he also concluded that it was silent prior to Claimant's work injury. Claimant's back is at risk and is inherently mechanical and unstable. People can have Grade I spondylolisthesis and do heavy manual labor all their life without any symptoms. A trauma, like Claimant falling one or two feet onto his feet and then buttock, is enough to cause a previously asymptomatic spondylolisthesis to become symptomatic. Regardless, Claimant has predominant symptoms of nerve root impingement. Therefore, Claimant really suffers from four separate conditions: (1) acquired spondylolisthesis, which is a defect in the pars inter articularis; (2) pre-existing asymptomatic spondylolisthesis; (3) broad base posterior lateral disc protrusion, herniated disc that abuts the L5-S1 nerve root; and (4) nerve root impairment/impingement.<sup>331</sup>

The impingement is caused by the disc rupture and the spondylolisthesis causes lumbar instability. Dr. Manale independently studied the 2005 MRI film and compared it to Dr. Glorioso's report. There were many levels of disc desiccation and bulging, but about 20 percent of 40 year old people who work heavy manual labor will have some disc desiccation. Dr. Manale agreed with Dr. Glorioso's interpretation that Claimant had a herniation at L4-5 and L5-S1 and a subtle focal contained herniation at 3-4. Neither Dr. Manale nor Dr. Glorioso was sure about L3-4. He could only conclude that there was some evidence of disc degeneration, but the main problem is the herniation at L5-S1 that is pressing on the nerve root.<sup>332</sup>

Dr. Manale disagrees with Dr. Katz's conclusion and plan. Dr. Katz did not have the EMG or nerve conduction study. Dr. Katz did not mention physical exam findings, which Dr. Manale thought were significant (i.e. atrophy and weakness). Dr. Manale reached his conclusions based on the fact that everything he looked at reflected that Claimant has a problem with his back, his spine, abnormal bony architecture, soft tissue disc, abnormal pathology, abnormal physical examination, and abnormal EMG. He does not disagree with Dr. Katz's ability, but he reached his conclusion with more facts than Dr. Katz. Dr. Manale had the advantage of the EMG and nerve conduction study. After reviewing the MRI films, Dr. Manale

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<sup>330</sup> Tr. 47-48, 73-74.

<sup>331</sup> Tr. 48-49, CX-28, p. 3.

<sup>332</sup> Tr. 49-51.

agrees with the radiologist's finding that Claimant has a herniation. He also thought the report from Southern Pain and Anesthesia was incomplete because the doctors did not have the additional MRI, x-rays, or EMG. Dr. Manale observed L5-S1 radiculopathy related to the herniated disc on the EMG.<sup>333</sup>

Assuming Claimant stepped on a 4 x 4, twisted his ankle and felt immediate pain, was lifted one to three feet and dropped, falling to the deck onto his buttock, it is Dr. Manale's professional opinion that Claimant could have aggravated or herniated the L5-S1 disc if Claimant's back had been asymptomatic for years prior to his fall. Dr. Manale could not explain why Claimant described different histories regarding his accident, except that Claimant did not start to feel back pain until several days after his injury. It is probable because there is no evidence that he previously had this neurological picture until now. In addition, when a disc herniates, as time goes by the disc space really narrows and bone spurs form. These phenomena are not present with Claimant. Therefore, Dr. Manale concludes that the fall is the significant injury that caused Claimant's current condition. His opinion is that Claimant had a slipped vertebra, degenerative disc disease, and bulging disc before his fall that made his disc weak enough that even the slightest amount of trauma ruptured the disc and caused his problems. Claimant's ankle pain could very well have masked Claimant's symptoms of back pain, especially if he was taking pain medication. The fall is the most likely cause of Claimant's back problems since there is no other evidence of trauma.<sup>334</sup>

Dr. Manale opined that Claimant is a candidate for surgery based on his objective neurological problems, EMG abnormalities and MRI abnormalities. However, the nature of the surgery will be tough to call – i.e. whether the disc should be removed or removal with fusion. Dr. Vogel's recommendation for a discography is not a bad idea, but decompression of the nerve roots at L5-S1 would help Claimant's lower extremity pain. Dr. Manale did not know if Claimant would ever regain the lost muscle power and Claimant will still have some dysfunction. If the nerve is permanently damaged, then he may not regain muscle power. Dr. Manale believes surgery will help relieve some of Claimant's symptoms of pain and atrophy; however, it will not cure him.<sup>335</sup>

Based on his review of the record, Dr. Manale would have considered Claimant temporarily totally disabled. If Claimant was asymptomatic prior to his work accident, severely sprained his ankle and did not immediately feel back pain after falling on his buttocks and then two days later woke up with stiffness and pain in

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<sup>333</sup> Tr. 51-53.

<sup>334</sup> Tr. 53-57, 65-74.

<sup>335</sup> Tr. 57-59; CX-28, p. 3.

his back after returning to work, it is more likely than not that Claimant aggravated the pre-existing spondylolisthesis and herniated the L5-S1 disc pressing against the L5-S1 nerve root.<sup>336</sup>

Although he only treated Claimant one time, he prescribed him medication because Claimant did not have any medication and Dr. Manale felt sorry for him. He prescribed 30 day supplies of Soma, Xanax, and Lortab and scheduled a follow-up appointment. He did not put it in his report, but Claimant told him that he did not have any medication. He would not have given Claimant medication if he already had another doctor prescribing them for him because Claimant only needs one doctor at a time to give him medication and the drugs have a potential for abuse. He also told Claimant to return for a follow-up in two months.<sup>337</sup> He is not sure if his office makes patients sign a pain management contract. He did not recall if Claimant told him when he received his last prescription from any physician. Another doctor's prescriptions should not have overlapped his. It would not be inconsistent for Dr. Manale to prescribe Claimant medication if he ran out of the medication prescribed by Dr. Mogan and could not get an appointment with the doctor quick enough for a refill. However, if Claimant had a follow-up scheduled then Dr. Manale's prescription should be void. If a person has pain, like Claimant, and cannot get relief from surgery, it is not uncommon for that person to seek relief with pain medication. But, there is no excuse for getting medication from more than one doctor. Dr. Manale prescribed Claimant medication because he believed it was justified based on the pain Claimant experienced. He believed Claimant's subjective complaints of pain and the objective tests explained the basis for the pain. Based on the objective findings, Dr. Manale is not surprised by Claimant's subjective complaints.<sup>338</sup>

Dr. Manale concluded that conservative therapy had not worked for Claimant. He is aware that there were recommendations for epidural injections and other conservative treatment. He does not believe that those treatments were conducted. Regardless, Dr. Manale would not change his opinion because he does not believe the conservative treatment will work for Claimant. He would recommend those treatments to help relieve pain, but it will not put the disc back in place. Those types of treatment will only temporarily treat his pain and Claimant would be best served by a mechanical treatment like surgery. Smoking reduces the success and recovery rate of a bone graph fusion and some doctors would not perform the surgery if a man smokes because smoking contributes to bone graph failure.<sup>339</sup>

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<sup>336</sup> Tr. 59-61.

<sup>337</sup> EX-31.

<sup>338</sup> Tr. 61-67, 80-82, 84-86.

<sup>339</sup> Tr. 69-77.

The degenerative disc disease more than likely pre-existed because that along with spondylolisthesis weakened his spine. A Grade I spondylolisthesis can in and of itself result in a disc herniation without trauma. Dr. Manale was aware that Claimant got a Marcane injection in his ankle on 10 Jan 03. This might change his opinion about masking issues, but it is only a local anesthetic and wears off in a few hours. The spondylolisthesis can cause the symptoms Claimant currently experiences without a disc herniation if there is a proliferation of some of the soft tissue components of the slip and the lesion where the bone dissolves. Sometimes soft tissue can grow scar tissue fiber cartilage and pinch a nerve root. If there was no trauma, Dr. Manale still does not believe Claimant's issues are solely attributable to the pre-existing spondylolisthesis because of the disc rupture. If it was not traumatically induced, then it could have been caused by a combination of the spondylolisthesis and the non-traumatic disc herniation.<sup>340</sup>

If Claimant only became aware of the back pain about seven days after his accident, he should have reported that back pain when he became aware, especially if Employer wanted him to return to work.<sup>341</sup>

***Dr. Ralph P. Katz testified live and at deposition in pertinent part that:***<sup>342</sup>

He is a board certified orthopedic surgeon. He conducted an independent medical examination upon Claimant on 30 Nov 05. Claimant injured himself when a load shifted. As the load shifted, he twisted his ankle. He held onto the cable as it went up, but then fell to the ground directly onto his lower back. He denied any loss of consciousness, but stated his ankle was quite swollen and painful. However, none of the forms Claimant filled out for Employer or the Department of Labor noted a back injury; they only reflected an ankle injury as a result of a work accident. In contrast, Claimant's chief complaints to Dr. Katz were his ankle and back pain, but his main focus was his back. Claimant also informed Dr. Gudan on 06 Feb 03 that he landed on his back after he hurt his ankle, similar to the description he gave Dr. Katz. Claimant informed Dr. Katz that he was treated conservatively, tried to return to work after two weeks, went home and never returned to work. Claimant complained to Dr. Katz of low back pain and difficulty doing any activities. Claimant told Dr. Katz that he woke up with pain in his back and has more pain arching his back in extended position than with flexion. He believed Claimant's statements because it's the foundation of patient doctor trust.<sup>343</sup>

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<sup>340</sup> Tr. 77-80.

<sup>341</sup> Tr. 89.

<sup>342</sup> Tr. 90 – 136; EX-1; EX-8.

<sup>343</sup> Tr. 90-91, 108-109; EX-1, pp. 7-20, 23, 40-43; EX-8, p. 1.

A person who suffers enough trauma to cause a herniation, not a protrusion, will have severe low back pain. An acute disc herniation usually occurs within several hours to 24 hours with significant leg pain within several days. With an ankle injury like Claimant's and then a disc herniation, Claimant would have felt pain in both areas. Physical examination revealed no palpable tenderness in the lower back. In fact, when palpating his back, Claimant stated it felt better. Claimant was able to forward flex to his ankle with some complaints of pain. He had a lot of pain getting into extension by 20 degrees. He had some discomfort with lateral rotation and side bending in the central lower back around 5/1 level. Claimant denied any upper buttock or sciatic notch pain. That type of pain would have indicated either sciatic nerve irritation or the beginning of a radicular type pain, which is indicative of a disc herniation. There was no evidence of tension signs. X-rays revealed that Claimant had bilateral spondylolysis defect at L5 more prominent on the left. L5 is the most common level that it appears in. It is usually a defect a person is born with, but it can come about traumatically. However, the radiographic appearance is different for a traumatic incident than for someone born with it. Dr. Katz opined that Claimant was born with his spondylolysis defect.<sup>344</sup>

Dr. Katz stated that he spends about 20 to 30 minutes questioning, interviewing and examining the patient. He also spends time reviewing a patient's medical history. Dr. Katz did not have any independent recollection as to how long he spent with Claimant and could not dispute Claimant's statement that it was only five minutes. However, he concluded that he spends enough time with a patient to get the correct information he needs to generate an opinion. It would be highly unusual for him to only spend five minutes with a patient because he could not get enough information in that short amount of time. Dr. Katz does a "fair amount" of independent medical examinations and his clinic charges \$1,000.00 per IME. His IMEs are about two-thirds for defense and one-third for plaintiff. Regardless of who refers a patient to him, he tries to render an independent assessment to the best of his ability.<sup>345</sup>

Dr. Katz also examined Claimant's ankle. There was no gross swelling and the pain and bruising had resolved. Claimant had full range of motion and no instability. There are three grades of classifications for an ankle injury. A Grade III injury is where the ligament is completely disrupted with some instability in the ankle. A Grade II ankle injury is when the ligament is severely strained and it's attenuated and has some laxity to it. The swelling tends to last for six to eight weeks at a time, but the pain can go on for three to four months. Although Dr. Katz did not treat Claimant's ankle and did not see Dr. Hubbell's report, Dr. Katz would not reject Dr. Hubbell's opinion that Claimant still had swelling in his ankle eleven months after his work injury. For Claimant's ankle to still be symptomatic

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<sup>344</sup> Tr. 109-110; EX-1, pp. 27 – 31; EX-8, pp. 4-5.

<sup>345</sup> EX-1, pp. 43-49.

that long after his injury, Dr. Katz conceded that it must have been a “very sprained and very painful ankle” injury.<sup>346</sup>

Upon review of his deposition transcripts related to Claimant he corrected “some terminology differences.” He originally classified Claimant’s back problems as congenital and spondylolisthesis in the old classification system because the old system put everything into one basket. The new system breaks it down into congenital, developmental, and acquired. However, his opinion remains the same – Claimant’s isthmic spondylolisthesis is pre-existing and something that probably started as early as age four. The change in terminology does not make a difference in his original opinion. He believes the spondylolisthesis is pre-existing because of the May 2003 MRI taken shortly after Claimant’s injury. The MRI reflected changes that do not come about in a very short period of time, “the desiccation, the narrowing of the disk space, the changes in the morphology of the disk. These are things that take place over the years. They don’t take place over a three or four month period of time.” These are radiographic signs that he can base his decision on that the changes are longstanding and Claimant’s work accident did not cause his spondylolisthesis. Basically, Claimant has degenerative arthritis in his lower back as well as a spondylolisthesis defect.<sup>347</sup>

He also had an opportunity to review diagnostic tests, other physician’s depositions, and medical records. The EMG nerve conduction study performed by Dr. Shamsnia in March 2006 reported that the L4 was normal. Another report by Dr. Shamsnia states there is an abnormality at L5-S1. Dr. Katz has a problem with this analysis because it does not isolate any particular nerve root and implies that it involves either one nerve or the other, when in fact, the only thing he sees involved with polyphasic changes was the L5 root findings. He uses EMG and nerve conduction studies as one of the tools to assess patients. There can be more than one root involvement, but the EMG, needle and conduction study reports should clarify the specific nerve root involved. The only thing he sees in Dr. Shamsnia’s reports is a discrepancy. If there is an L5 root abnormality that gives greater support for spondylolisthesis as opposed to a herniated disc because when you have a disc herniation at L5-S1 the most common root involved is S1. When you have spondylolisthesis, the most common root involved with the Grade I slip is the L5 root. Looking at the EMG report there is no activity in the S1 nerve root at all; it is all in the L5 root. Dr. Katz attributes that activity to spondylolisthesis.<sup>348</sup>

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<sup>346</sup> Tr. 110-113; EX-1, p. 28; EX-8, p. 5.

<sup>347</sup> Tr. 91-93, 100-102; EX-1, pp. 30-32, 51-60, 64.

<sup>348</sup> Tr. 93-95; 128-129; EX-8, pp. 2-4.

He checked Claimant for atrophy and his report specifically states that there was no asymmetry atrophy noted in the lower lumbar spine. He also did a complete examination of the lower extremities and would have noted the presence of asymmetry or atrophy, if they were present. Even though Dr. Mogan noted atrophy in September 2005 and Dr. Vogel noted atrophy in Claimant's left calf and thigh in January 2006, Dr. Katz claimed he did not miss anything during his examination because Claimant did not have atrophy. When asked if it would be a meaningful piece of information to do a visual inspection to check for atrophy, Dr. Katz testified that even if Claimant had atrophy it was probably coming from the pre-existing spondylolisthesis versus a disc herniation. A protruding disc at the L5-S1 level that just touches the nerve root is not going to cause atrophy in the person's left thigh or calf. To cause atrophy it must be actually deforming and squeezing the nerve root. Dr. Katz performed a visual examination upon Claimant and concluded that there was a very subtle change and difference, but it was not significant. Although a gross physical examination may be important, he needs a tape measure for an accurate measurement because there is always going to be some difference in peoples' legs.<sup>349</sup>

He also disagrees with Dr. Manale's statement that Claimant's attempts at conservative treatment have failed. Dr. Katz believes Claimant may benefit from epidural steroid injections, physical therapy, and a pars injection. A physical therapy program can help him strengthen the core abdominal and lower back muscles, which can help stabilize the spine and prevent irritation of his spondylolisthesis. These conservative treatment options have a high rate of success with Grade I spondylolisthesis patients. The injection can decrease the amount of swelling around the nerve root and possibly reduce the swelling of the disc, which can alleviate some pressure on the nerve and can stop the progression of any atrophy. There is no way to predict whether an injection is going to give someone temporary or permanent relief.<sup>350</sup>

He does not see any evidence of a disc herniation in Claimant's spine at any level, but there is a disc protrusion. A herniation is where the disc actually breaks through and is extruded, while a protrusion is not pushed out. This is supported by Dr. Manale's finding that Claimant had a negative seated straight leg raising test bilaterally. Someone with an acute disc herniation or even a longstanding one would have some tension signs with straight leg testing. Dr. Katz also believes that the disc protrusion is part and parcel to the spondylolisthesis complex and as such, is pre-existing. The posterolateral disc protrusion is touching against the thecal sac in the S1 nerve root, but did not compress it. If the nerve root is not

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<sup>349</sup> Tr. 95-96, 117-127; EX-1, p. 27, 61-64.

<sup>350</sup> Tr. 95-96; 126-128; EX-1, pp. 33-35.

displaced or physically compressed, then it will not cause atrophy. If a left posterolateral disc protrusion is compressing the S1 nerve root to where it is physically deforming and displacing the nerve root, it will cause calf pain and depending on how longstanding, it can also cause S1 root muscles to atrophy.<sup>351</sup>

He agrees with Dr. Hubbell's recommendation for epidural injections and if the epidural failed then trans-foraminal injections and possible facet blocks. The only difference between the injections is the way the needle is put in. The trans-foraminal injection is a little less traumatic. He also agrees with Dr. Aprill's opinion that Claimant should be treated conservatively and under no circumstances would he recommend surgery. Dr. Katz was not aware of whether Claimant underwent any type of injection treatment and had not seen any medical records reflecting that he has. Therefore, he must disagree with Dr. Manale's statement that conservative therapy has failed.<sup>352</sup>

A review of a report from the industrial medicine office on 10 Jan 03 reflects that Claimant's acute ankle pain could not have masked his back pain. On the day of Claimant's injury, Mr. Carruth gave him an intra articular ankle injection, Marcane, to his left ankle. The injection would have blocked any sort of pain response to the ankle which dismisses the possibility of a masking back pain. It is extremely unlikely for a patient not to respond to and feel pain relief from a Marcane injection. If the injection gets to the joint around the ankle and is properly placed, it goes to the nerves and the patient will feel relief, not a partial relief of pain. It is possible that if the ankle was so swollen that the area of best benefit cannot be identified, then the Marcane may not provide the relief it is intended to provide.<sup>353</sup>

In Dr. Katz's experience and in looking at the literature, he has not seen anything documenting people not having almost immediate back pain with an acute disc herniation. An acute disc herniation is when the disc ruptures through the annulus and is non-contained. However, with disc bulge, that is not associated with a spondylolisthesis, there can be some delay in the experience of back pain. Therefore, someone with such a severely sprained ankle with symptoms lasting beyond nine months could have masked onset of early back symptoms, but Claimant received an ankle injection which would have taken away all of his ankle pain. Had Claimant returned within a couple of days of treatment with complaints that the Marcane injection did not provide much relief, that his ankle was still hurting, and he was experiencing stiffness and soreness in his lower back then Dr. Katz would possibly have related Claimant's back problems to his fall.<sup>354</sup>

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<sup>351</sup> Tr. 96-97, 102-103, 123-125; EX-8, p. 5.

<sup>352</sup> Tr. 97-100; EX-1, pp. 36-37; EX-8, p. 6.

<sup>353</sup> Tr. 103-104, 115-116.

<sup>354</sup> Tr. 103-104, 113-116.

He did not place any restrictions upon Claimant in his report. However, when asked if he would put restrictions on Claimant shortly after his accident, he considered Claimant's back pain. He gave Claimant the benefit of the doubt and suggested that he should have been taken off work, provided with conservative treatment, mend, and then try to return to work at a later date. As of 30 Nov 05, Dr. Katz believed Claimant could return to work in a light to sedentary position. Claimant's back pain was caused by an aggravation of a pre-existing problem in his lower back; basically he strained his lower back. Dr. Katz opined that at the time he saw Claimant in November 2005, the aggravation resolved and Claimant's symptoms were just low back pain from a pre-existing pars defect. The pars defect is not related to Claimant's on the job accident in January 2003.<sup>355</sup>

If Claimant only rolled and twisted his ankle and there was no evidence of sustained trauma to the back, then there is no real reason for Claimant to have back pain unless he did something in his day to day activities that aggravated his spondylolisthesis defect. However, falling on the buttocks can aggravate and cause a previously asymptomatic spondylolisthesis to become symptomatic. The spondylolisthesis predates his work injury and was not caused by that injury. However, it is possible that the spondylolisthesis was aggravated by the fall. Claimant was symptomatic at the time of his examination on 30 Nov 05. He recommended conservative treatment and no surgery. He recommended epidural steroid injections, fluoro-pars injection and aggressive truncal stabilization.<sup>356</sup>

Dr. Katz noted in his reports that Claimant was positive for neurological problems because Claimant claimed he had left foot and leg numbness. Claimant explained that he occasionally gets pain shooting into his left lower extremity all the way to his foot, including his toes. This is possibly consistent with either an impingement of the L5 or S1 nerve root.<sup>357</sup>

Dr. Katz has disagreed with doctors before, but did not know the frequency in which it occurred. It is not unusual for two different doctors in the same field to have different opinions about causation and findings of an MRI. He disagrees with Dr. Glorioso's interpretation that Claimant has a herniation and feels Claimant only has a protrusion at one level. The protrusion touches the thecal sac and nerve root, but does not deform it. Dr. Katz did not specifically look at the film finding "levoconvexity of the lumbar spine . . . with loss of lumbar lithosis[.]" but concluded that it did not provide a lot of information when he is specifically looking at the disc pathology. As to Dr. Vogel's finding that Claimant's current left and previous right scoliosis was caused by spasms in the muscles surrounding the spine, Dr. Katz responded "there are so many factors . . . that can cause somebody to lean one way or another . . ." However, he admitted that a spasm can

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<sup>355</sup> Tr. 104-107; EX-1, p. 38.

<sup>356</sup> Tr. 107, 129-130.

<sup>357</sup> Tr. 116-118.

cause a person to lean to the left one day and a month or two later it can cause them to lean the other way. It can also be muscle spasms that have nothing to do with nerve root compression. But muscles spasms are a protective mechanism which can be secondary to someone having a compressed nerve.<sup>358</sup>

Claimant merely had some pre-existing conditions which were aggravated by his fall, if there was indeed a fall. After an aggravation, a person may be symptomatic for a couple of weeks and then get better and back to the pre-fall baseline of discomfort. It is not that he thinks the doctors are completely unreasonable for suggesting surgery; however, he feels that the majority of spondylolisthesis patients can get better with conservative treatment, epidurals, physical therapy, and anti-inflammatories. There is “a small subset of people that just have chronic pain that can go on and benefit from surgery.” “[I]n the arena of litigation and the arena of work comp, the results of surgery in that patient population is dismal and most people would recommend really staying away from that.” However, without first doing conservative treatment, it would be unreasonable to perform surgery on Claimant. If the conservative treatment did not work and he continued to have pain, then surgery would be an option.<sup>359</sup>

***Dr. Michael Puente testified by deposition in pertinent part that:***<sup>360</sup>

He is board certified in neurology since 1990. He does not have an area of sub specialization. He was asked to perform an independent medical examination on Claimant. He evaluated Claimant on 27 Apr 06. Prior to evaluating Claimant, he reviewed Claimant’s medical records, including Drs. Shamsnia, Vogel, Katz, Greenberg, and Mogan. Claimant provided a medical history that he was injured on the job in January 2003 when in the process of hooking up a crane with heavy cables he twisted his ankle on a 4 x 4 and grabbed onto a cable. The cable started lifting off the ground and Claimant fell onto his buttock from about one to two feet off the ground. He had immediate severe left ankle pain to the point where he could not stand on it or walk. Claimant did not attribute any problems to his back at the time because he thinks his ankle pain was so overwhelming to notice. He started noticing problems with his back over the next few days and has had problems with his back ever since. If a patient’s history is accurate, then often it is the most important piece of information to establish the cause of relationship.<sup>361</sup>

Dr. Puente reviewed various accident histories that Claimant provided to several sources closer to the time of the accident. On the LS-202, Employer’s First Report of Injury, Claimant stated that he stepped backward onto a 4 x 4, injuring his ankle. The Employer’s Root Cause Analysis states that Claimant was unloading

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<sup>358</sup> Tr. 130-133.

<sup>359</sup> Tr. 133-136; EX-1, p. 35.

<sup>360</sup> EX-37; CX-36.

<sup>361</sup> EX-37, pp. 5-14.

casing piping and inadvertently stepped off an additional bundle of pipe onto a 4x 4 inch block and turned and sprained his left ankle. Chevron Contractor's Report of Occupational Injury or Illness states that he stepped off of a 4 x 4 and sprained his left ankle. The Production Management Companies' accident report provides a handwritten statement by Claimant that he stepped off of a 4 x 4 injuring his ankle. The LS-203, Employee Claim for Compensation, which was completed by counsel for Claimant, states that he tripped and hurt his left ankle. The medical report from Dr. Reavill states that he twisted his ankle while at work on 09 Jan 03. None of the reports mention that Claimant injured his back, too.<sup>362</sup>

Claimant presented to Dr. Puente with complaints of pain in his lower back, pain in the left buttock area, left leg becomes stiff and sore and has shrunk compared to the right side. He also complained of sporadic numbness in his middle digits of his left foot. Claimant also provided him with a medical history, including high cholesterol, 20 year old motor vehicle accident causing occasional pain across his lower back for two weeks, and no other problems until his work injury. Claimant reported that he treated with various doctors and felt like he was not getting anywhere.<sup>363</sup>

Upon reviewing the medical records and examining Claimant, Dr. Puente agrees with the diagnosis of spondylolisthesis. X-rays are better than anything else for diagnosing spondylolisthesis. Spondylolisthesis is the slippage of one vertebra onto another. Spondylosis, on the other hand, is a term used to describe arthritis or degenerative bond disease. The symptoms of spondylolisthesis usually include pain of the spine in the area involved and if significant enough, it can also cause radicular leg pain. Spondylolisthesis can also cause nerve impingement slowly over years. A slippage also worsens with age or it can happen more acutely with an injury. With the bone being out of alignment, the nerve becomes impinged or kinked as the bones slip past each other. If the nerve root impingement from spondylolisthesis is in the lumbosacral spine, then there is generally pain into the legs and groin area. If another cause cannot be found, then it is fair to say that if someone experiences pain in their legs or groin and has spondylolisthesis that it would be caused by nerve root impingement from the spondylolisthesis. Spondylolisthesis can also cause disc bulging from the wear and tear of the bones being out of position, which can also cause a kink in the nerve root.<sup>364</sup>

Claimant also has degenerative disc disease as determined by his x-rays and MRI films at the L5-S1 level where his spondylolisthesis is. There can also be an argument for degeneration at L4-5. A patient gets spondylolisthesis first and develops degenerative disc disease from years of wear and tear at that spot. Degenerative disc disease can also cause disc bulging. One can also have

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<sup>362</sup> EX-37, pp. 14-21.

<sup>363</sup> EX-37, pp. 21-23.

<sup>364</sup> EX-37, pp. 23-27.

radicular leg pain with degenerative disc disease. Claimant's disc bulging caused his radicular pain based on the history Claimant provided and Dr. Puente's examination. Claimant's L5 or S1 nerve roots, or a combination of the two, are impinged. Spondylolisthesis combined with degenerative disc disease makes a person more susceptible to problems with back pain or radicular pain. Degenerative disc disease can often times be at multi-levels. Someone with spondylolisthesis and degenerative disc disease can experience disc bulging without a trauma occurring.<sup>365</sup>

Dr. Puente performed a physical examination, which revealed that Claimant walked with a slight limp to his left leg, but he otherwise did not appear to be in tremendous discomfort. He was able to undress, move around, sit, and stand with no significant discomfort detected. Examination of Claimant's back was fairly unremarkable and there were no muscle spasms or tenderness. He did not have tenderness in his sciatic notches either. He had an abnormal straight leg raise by 20 degrees. Atrophy was visible to the naked eye and was documented by actual measurements. He later walked without a limp. He believes Claimant's atrophy is caused by his nerve root impingement at L5-S1 and could not see what else could cause it. He further believes that the impingement is caused by a combination of a disc problem and spondylolisthesis at L5-S1.<sup>366</sup>

He does not necessarily agree with Dr. Shamsnia's opinion that the EMG studies were consistent with left perineal neuropathy because he based his opinion on the fact that he obtained a higher amplitude with stimulation of the right perineal compared to the left. Although that might be a valid finding, in Dr. Puente's experience there is a certain amount of area built between the amplitude on one side than the other. Unless it is actually abnormal, Dr. Puente does not call it as Dr. Shamsnia did. Based on the EMG studies, he would not have diagnosed Claimant with left perineal neuropathy. That does not mean that it is not there. After completing the physical examination, Dr. Puente diagnosed that Claimant, as a result of his work injury, suffered from chronic L5-S1 radiculopathy on the left which resulted in his current complaints of left lower back pain, left leg pain, and atrophy of the left calf. However, Dr. Puente's report from the 13 Jul 06 EMG and nerve conduction study<sup>367</sup> states his impression as "abnormal study suggesting a possible left peroneal mononeuropathy vs an L-S plexopathy or radiculopathy" since the nerve conduction study revealed that the left peroneal motor potential amplitude was reduced.<sup>368</sup>

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<sup>365</sup> EX-37, pp. 27-31.

<sup>366</sup> EX-37, pp. 31-34.

<sup>367</sup> EX-39.

<sup>368</sup> EX-37, pp. 34-37; CX-38, p. 3.

Assuming that Claimant only twisted his ankle and did not fall onto his buttock, then Dr. Puente would conclude that Claimant's work injury did not cause his back problems. If there was no traumatic incident, Claimant's back problems, nerve irritation, and atrophy are a result of spondylolisthesis and degenerative disc disease on a long-standing basis.<sup>369</sup>

Dr. Puente believes Claimant could get better with epidural steroid injections, physical therapy, work hardening program, and a pain specialist. He would possibly recommend narcotic pain medication in small amounts. If he treated Claimant on a long term basis he would feel comfortable prescribing 5 milligrams of Vicodin one to two times daily, no more. A person should never get narcotic pain medication from more than one person. The more narcotic medication one has access to stop pain, the more apt one is in getting addicted. Dr. Puente does not use written pain management contracts in his office. He usually just does an oral pain contract with his patients. If he determined that one of his patients received pain medications from more than one doctor he would seek corrective action and confront the patient. Sometimes he will give them another chance and sometimes he would refuse to provide further treatment – it all depends on the patient himself.<sup>370</sup>

Dr. Puente believes a lumbar fusion is a drastic measure and should only be done as a last resort. He would tell Claimant that he should not have surgery under any circumstances until he has exhausted all other options, such as injections, pain management, and physical therapy. The pain management doctor can give Claimant the injections and prescribe pain medications and muscle relaxers. Sometimes they also provide anti-depressants which can help pain patients. Claimant should have three epidural injections. If the injections along with physical therapy and pain management do not provide relief, surgery may be indicated. In addition, because welders tend to work in tight, uncomfortable situations, he believes it is possible that Claimant will not be able to return to his usual employment. However, based on everything he observed, Dr. Puente thinks Claimant could work “in many forms of employment, maybe not heavy lifting but I don't think he would necessarily be restricted to sedentary activity either.” He believes Claimant could work a light duty job.<sup>371</sup>

Assuming a person sustained an injury to his back which caused bulging at the L4-L5 and L5-S1 levels, he believes it would be noticeable immediately. However, it is possible that the degree of pain in Claimant's ankle could have masked any symptoms in the back for a few days. Based on the history Claimant provided, it is actually probable that Claimant did not feel the back pain for several days due to the ankle injury. As of 02 May 06, Claimant had not yet reached maximum

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<sup>369</sup> EX-37, p. 37.

<sup>370</sup> EX-37, pp. 37-41.

<sup>371</sup> EX-37, pp. 41-42, 45-47.

medical improvement. Dr. Puente reviewed both MRI films and found a bulge as opposed to Dr. Aprill's diagnosis of a herniation. However, it is a matter of semantics and degree that is subject to the interpretation of the interpreter or reviewing physician. He thinks it is reasonable that the L5-S1 is effacing the left L5 nerve root. Dr. Puente believes bulging and protrusion mean the same thing. Herniation means beyond bulge or protrusion – it is a tear of the annular wall where the nucleus pulposus extrudes out of the disc. He does not find that present in Claimant's MRI films. He considers there to be a bulge or a protrusion of the L5-S1 disc pressing against the L5-S1 nerve root. The epidural injections would reduce the inflammation of the inflamed nerve root and morphine would deaden the pain for a period of time. It only sometimes provides permanent relief.<sup>372</sup>

Epidural injections do not work in isolation. It must be combined with pain management and physical therapy to get full effect. It is Dr. Puente's opinion that Claimant could do "quite well" with conservative treatment. However, ideally, Claimant should have had it done three years ago and may have spared himself three years of misery. Regardless, he can still be in a good position and be productive if he is in the right state of mind. It will never completely get rid of his back pain. A lot of people have back pain and still are productive members of society and functioning. Dr. Puente believes Claimant can function in a productive capacity following appropriate treatment.<sup>373</sup>

Dr. Puente believes Claimant suffers from the L5-S1 nerve root being impinged by a combination of the L5-S1 protrusion and the slippage of the vertebrae at L5-S1. He believes it is somewhat unusual that Claimant has atrophy but no actual weakness. Surgery is usually suggested for someone who has weakness of a muscle (although it can be argued that atrophy itself means the same thing). Dr. Puente just believes the atrophy has been there for a long time and may have even plateaued. Claimant has adapted very well. It is a reasonable statement that other doctors could disagree with his recommendations and recommend surgery. Given the length of time the nerve root has been impinged, it is more likely than not that the damage to the nerve root is permanent, i.e. atrophy. Even with surgery, the nerve will still be damaged, but it could prevent further damage. It does not mean that Claimant would automatically continue to have pain after the surgery. Given the history Claimant provided that he twisted his ankle and fell on his tailbone and was asymptomatic for back pain, it would be a reasonable assumption that his work injury activated, aggravated, or precipitated the previously asymptomatic spondylolisthesis and made it symptomatic and more likely than not also caused the protrusion of the L5-S1 disc.<sup>374</sup>

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<sup>372</sup> EX-37, pp. 42-45, 47-49.

<sup>373</sup> EX-37, pp. 49-51.

<sup>374</sup> EX-37, pp. 51-54, 58-59.

Dr. Puente would not be comfortable being Claimant's treating physician when he takes four to five pain medications per day to try to control his symptoms. He always wonders if they actually need that much medication or if they are hooked. However, he admits that he has only seen Claimant one time. If the pain is really that severe, then that would be one of the factors he would consider in deciding if surgery is appropriate and necessary.<sup>375</sup>

Dr. Puente could not make a determination as to Claimant's employability based on one visit. He believes Claimant can improve and become employable. He would suspect that at the present time Claimant is not employable, based on the amount of pain medications Claimant needs and the fact that he has not received any of the other recommended treatment.<sup>376</sup>

***Dr. Robert Applebaum testified by deposition in pertinent part that:***<sup>377</sup>

He has been a board certified neurological surgeon since 1976. He has also been an assistant professor in the surgery department at LSU since 1973. He has not actively taught in several years. He was asked to perform an independent medical examination of Claimant. He did not review all of the medical records prior to examining Claimant. However, he conducted a physical examination, and then reviewed the provided diagnostic films and records. He examined Claimant on 15 Jun 06. Claimant had complaints of pain in his lower back and weakness and numbness in his left leg since his work injury. He hurt himself when he fell and struck his lower back and left ankle. He noticed immediate pain in his left ankle and sought treatment. He received injections in his ankle and was released to return to work two weeks after his accident. He also started to note increasing pain in his low back. Claimant saw a chiropractor and was treated with heat and electrical stimulation with no relief of symptoms.<sup>378</sup>

Dr. Applebaum reviewed histories of the accident that Claimant provided to various sources. The Production Management Companies Supervisor's Report of Employee Occupational Injury or Illness does not mention that Claimant fell and struck his lower back. The LS-203, Employee's Claim for Compensation, also does not mention anything about falling and hitting his back. It only mentions his ankle injury. The Contractor's Report of Occupational Injury or Illness does not mention any injury to his lower back and simply states left ankle sprained. The form from Dr. Reavill does not mention a fall or striking of his lower back either. From a purely medical standpoint, it is important to obtain an accurate mechanism of injury for treatment purposes because it helps explain the possible consequences of a particular injury.<sup>379</sup>

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<sup>375</sup> EX-37, p. 54.

<sup>376</sup> EX-37, pp. 55-58.

<sup>377</sup> EX-35; CX-37.

<sup>378</sup> EX-35, pp. 7-16.

<sup>379</sup> EX-35, pp. 16-24.

Claimant informed him that he had an MRI of his lumbar spine in May 2003 and had treated with another neurosurgeon, Dr. Vogel, who recommended surgery. Dr. Katz recommended epidural steroid injections. Dr. Applebaum does not believe that Claimant underwent the epidural steroid injections as recommended. He has no record that Claimant ever had injection therapy or treatment. Claimant told him that he had aching and constant pain in his low back. The pain increases with activity and diminishes with rest. He denied any radicular pain into his leg, but noted intermittent numbness in the lateral posterior calf and foot. The numbness increases with prolonged sitting. He also complained of vague weakness in his left leg, but could not be very specific. He denied any difficulty with his right leg. He denied any previous difficulty with his back and legs. Claimant takes six to eight Lortab daily, as well as Soma and Xanax, for relief of symptoms. Dr. Applebaum asks follow-up questions to clarify his patients' complaints of pain and to distinguish which part of the body is affected. That is how he delineated Claimant's complaints of pain.<sup>380</sup>

He also conducted a physical examination during Claimant's 15 Jun 06 evaluation. The examination was limited to Claimant's back and legs. Examination of the back revealed normal range of motion. He also palpated Claimant's back for muscle spasm or rigidity and found none present in his back. This is very significant because even with a lumbar strain one would expect some spasm or rigidity if the patient was having pain. The fact that Claimant had no spasm or rigidity would rule against any significant pain in the back. Claimant also had a normal curvature in his back. The bilateral straight leg raises were also negative except for some tightness in the hamstring muscle in the back of his thigh on the left at 80 degrees. Hamstring tightness does not indicate a neurological problem. He determined hamstring tightness by questioning Claimant about what was going on at the time he complained of discomfort. He said it was tight, but not painful. Dr. Applebaum specifically asked Claimant about it and he said it was tightness, not pain. The tightness could be from deconditioning or due to anything – it is not an uncommon finding. It is not a sign of nerve root irritation. If the test was positive it would help determine the presence of nerve root irritation or radiculopathy. The most common cause is a disc irritating a nerve root causing pain or irritation of his nerve root. The straight leg raise stretches the sciatic nerve and would cause Claimant to complain of pain in his leg. The pain from radiculopathy of the sciatic is from a different location than hamstring tightness. The location with nerve root irritation is into the calf or foot while the hamstring is at the back of the thigh.<sup>381</sup>

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<sup>380</sup> EX-35, pp. 24-29.

<sup>381</sup> EX-35, pp. 29-34, 69-80.

The bowstring sign test, which is basically the same test as the straight leg raising test, did not cause Claimant any pain or discomfort either. The Patrick Signs Test is performed by bending the knee and rotating at the hip to determine hip joint dysfunction and was also negative. Dr. Applebaum tested Claimant's muscle strength and there was no weakness or twitching of the muscle present. He did notice atrophy in the left calf. The left calf was about  $\frac{3}{4}$  inches smaller than on the right. Dr. Applebaum does not know the cause of the atrophy. A repeat electrodiagnostic study could help determine the cause of his atrophy. Claimant has a lot of atrophy for it to be from a single nerve root irritation without other findings. Regardless, he would not agree that Claimant must be suffering if the atrophy came from the nerve impingement. He has no reason to doubt Claimant's sincerity "other than evidence of his drug seeking behavior." Claimant's sensory examination was unremarkable and no pathologic reflexes were noted. If Claimant did not feel the pin being stuck in his leg it is not encompassed in the finding that the sensory examination was "unremarkable."<sup>382</sup>

Once he completed his examination, Dr. Applebaum rendered his impression of Claimant. Based on the history Claimant provided, he sustained an injury to his back and left leg in an accident in 2003. His examination showed no significant mechanical findings (range of motion, curvature, straight leg test, bowstring sign) and moderate neurological findings. Claimant's 2005 MRI is consistent with degenerative changes as it only showed a loss of water content and slight narrowing at L5-S1. It is part of the natural aging process. There was minimal bulging of the disc, but Dr. Applebaum did not feel it was clinically significant. He did not believe the disc was ruptured and did not see any evidence of nerve irritation. There was minimal subluxation of the L5 anteriorly on S1, which is some slippage anteriorly of the body of L5 on the body of S1 due to instability, but it is very mild. The x-rays revealed bilateral spondylolysis at the L5 lumbar vertebra. It is generally a congenital defect which is present from birth and may or may not be symptomatic for many years or ever. Dr. Applebaum did not feel the spondylolisthesis was clinically significant.<sup>383</sup>

It is Dr. Applebaum's impression that Claimant did not have disease or damage involving his spinal cord or nerve roots. Clinically, Claimant did not have radicular pain and no significant mechanical findings present in his low back that would indicate nerve root irritation. He did have atrophy, but the nature of it was unclear. Dr. Applebaum concluded that Claimant was a candidate for epidural steroid injections because of his spondylolisthesis and degenerative disc disease. He does not believe Claimant needs any surgical intervention.<sup>384</sup>

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<sup>382</sup> EX-35, pp. 34-36, 99-103.

<sup>383</sup> EX-35, pp. 36-41.

<sup>384</sup> EX-35, pp. 41-43.

Dr. Applebaum disagrees with Dr. Shamsnia's opinion that the nerve innervating the gastrocnemius muscle is impinged causing the calf muscle to die. The disc is not pressing on the nerve root. There was no evidence of weakness. However, there is atrophy in his calf. Dr. Applebaum was surprised that Claimant's other physicians did not notice the muscle loss. Muscle loss can be caused from an impinged nerve at L5-S1. Epidural steroid injections could help provide some relief of pain. An epidural steroid injection can also help with the instability and inflammation of the spine caused by spondylolysis. If Claimant had asymptomatic spondylolisthesis, then fell on his buttock and gradually developed severe pain, Dr. Applebaum opined that the fall caused the previously asymptomatic conditions to become symptomatic.<sup>385</sup>

Dr. Applebaum does not agree with Dr. Vogel's assessment that Claimant is a surgical candidate. He does not believe there is anything surgical that will help Claimant with his symptoms. He believes Claimant should be treated with epidural steroid injections. Spondylolysis causes some instability and can cause inflammation within the spinal canal. An epidural steroid injection can significantly help or relieve that pain completely. It is also a rather relatively benign procedure which is very safe and might afford Claimant some relief from his symptoms of pain in his low back with no radicular component to his pain symptomatology. The fact that Claimant has no radicular pain weighs in favor of Dr. Applebaum's impression that Claimant's complaints are related to spondylolysis, spondylolisthesis, and degenerative disc disease as opposed to a ruptured or herniated disc. Dr. Applebaum claimed that he met with Claimant a total of 30 minutes to take a history and perform a physical examination. He denied that it only took 10 minutes. He has no idea what time his staff brought Claimant into the office. If he has a patient that is late, he will go to the hospital and take care of urgent business. He routinely gives a patient a 30 minute grace period for an appointment. If they are more than 30 minutes late, then his office cancels the appointment. He could not recall whether his office informed him that Claimant's wife called and said Claimant was stuck in traffic.<sup>386</sup>

If the spondylolysis was evident in Claimant's 2003 MRI than it is Dr. Applebaum's opinion that more likely than not, the spondylolysis was present before Claimant's 2003 work accident. In addition, if the spondylolisthesis and degenerative disc disease were present on the 2003 MRI, then Dr. Applebaum also believes those conditions pre-existed Claimant's 2003 work injury. Bilateral spondylolysis at the L5 level and degenerative disc disease are known to cause the types of symptoms Claimant is reporting. Epidural steroid injections can help Claimant with his spondylolysis, spondylolisthesis, and degenerative disc disease.<sup>387</sup>

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<sup>385</sup> EX-35, pp. 91-95.

<sup>386</sup> EX-35, pp. 43-45, 65-74.

<sup>387</sup> EX-35, pp. 45-47.

Claimant told Dr. Applebaum that he took between six to eight Lortabs daily, as well as Soma and Xanax. Dr. Applebaum believes this is too much narcotic medication. Dr. Applebaum prescribes medication to his patients. He has heard the term “drug-seeking behavior” before. It is where an individual starts to exaggerate their pain for the purpose of obtaining narcotic medication for personal or other use. Patients sometimes also doctor shop to get the prescriptions they want. Filling prescriptions at several different pharmacies from different physicians is another component of drug seeking behavior. He is not familiar with the term “diversion of prescription medication.” Dr. Applebaum reviewed Claimant’s pharmacy records and several actual prescriptions issued to Claimant.<sup>388</sup>

Dr. Applebaum agrees with Dr. Chiverton’s assessment that Claimant is engaged in drug seeking behavior. On 13 Jul 05 Folsie pharmacy dispensed the prescriptions Dr. Chambers wrote on the same day. On 15 Jul 05, Bellmeade Discount Drugs filled a prescription for Hydrocodone and Soma. On 09 Aug 05, Claimant obtained an additional prescription from Dr. Chiverton for Hydrocodone. On 24 Aug 05, Folsie pharmacy dispensed the Hydrocodone and Soma from Dr. Chiverton. On 01 Sep 05, Claimant filled a prescription for Soma and on 08 Sep 05, he filled a prescription for Hydrocodone at Walgreens pharmacy. On 20 Sep 05, he filled a prescription for 42 Hydrocodone and 28 Soma. Claimant also filled a prescription for Hydrocodone at Walgreens on 19 Sep 05. Claimant filled a prescription on 07 Oct 05 at Fred’s pharmacy for 180 Hydrocodone, 30 Xanax, and 120 Soma. Based on Claimant’s prescription history, Dr. Applebaum opined that Claimant is using an excessive quantity of Soma and Hydrocodone. It indicates either drug abuse or drug dealing. However, when a herniated disc presses on a nerve root enough to cause atrophy, the condition would be painful. If there was a ruptured disc pressing on the nerve, eight Hydrocodone could be sufficient to help the person with his pain. It would not relieve the pain, but it would help.<sup>389</sup>

There are doctors who prescribe eight Hydrocodone per day and it is considered acceptable medical practice to relieve pain. He hopes that the doctors are doing it for medical reasons and not for financial gain. Soma helps relieve muscle spasm. He did not make a notation as to when the last time Claimant took Soma prior to his evaluation. He did not determine how many Hydrocodone pills Claimant took in one year. Nevertheless, each prescribing physician gave Claimant more narcotics than Dr. Applebaum would ever give one individual. Generally, if a person has as much pain as Claimant, he expects to see more mechanical findings. Typically, he does not give a patient more than one pain pill every six hours. If that does not relieve the pain, Dr. Applebaum would want to know why. If he had

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<sup>388</sup> EX-35, pp. 47-49.

<sup>389</sup> EX-35, pp. 49-63, 92-96.

a patient with a herniated disc causing atrophy and was taking four Hydrocodone per day, he would only recommend surgery if there was a reason to operate. He would want more than just atrophy in the muscle. He would want mechanical findings consistent with nerve root irritation. He would not operate on the basis of atrophy alone.<sup>390</sup>

Dr. Applebaum would not place any physical restrictions or limitations concerning employment upon Claimant, at least from a neurological standpoint. He would defer to an occupational medicine specialist regarding the spondylolysis about whether it prohibits Claimant from doing heavy lifting. There is no medical basis to restrict Claimant from working a sedentary job.<sup>391</sup>

Dr. Applebaum still performs about four to five surgeries per week, including craniotomies, laminectomies, anterior surgical fusions, removal of clots, and peripheral nerve surgery. He would not recommend surgery for a patient who has a herniated disc at L5-S1 on the left side that is impinging a nerve root, a positive EMG and nerve conduction study for left L5-S1 radiculopathy, MRI shows a herniated disc pressing against the nerve root, atrophied left calf, and pain for three years. Dr. Applebaum would first want to know where the pain is and what the physical examination showed. He would look for radicular pain. Radicular pain does not usually come and go. Taking around eight narcotic pain medications and Soma in one day may mask radicular pain to some extent, but per Claimant, he had not taken medication for four hours prior to his examination. The examination revealed that Claimant did not have radicular pain that day or within the last few weeks. The numbness in Claimant's leg followed a known anatomical pattern. It could be that the disc was pressing on the left L5-S1 nerve root or it could be perineal nerve palsy.<sup>392</sup>

Dr. Applebaum was shown a form completed by a chiropractor on 06 Feb 03 which stated that Claimant hurt his left ankle and lower back while at work. It specifically stated that Claimant twisted his ankle on a 4 x 4 under the load they were lifting, caught himself, the block from the crane lifted up, he let go and fell, and landed on his backside. Claimant reported to the chiropractor immediate ankle pain with a later onset of back pain. Dr. Applebaum believes that it is probably true that if a person has an accident to a part of his body and symptoms show up within seven days, then causation has been established. Dr. Applebaum understands how painful an ankle sprain can be. Just because Claimant's ankle was still symptomatic with swelling 10 months after he injured his ankle does not mean that it was a very severe sprain. Dr. Applebaum would want some physical corroboration and some orthopedic evaluation before he would render an opinion as to severity. People with ankle sprains re-injure it if they have some weak

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<sup>390</sup> EX-35, pp. 96-98, 101-105.

<sup>391</sup> EX-35, pp. 63-65.

<sup>392</sup> EX-35, pp. 80-84.

ligaments. A severe ankle pain may not necessarily mask the initial onset of symptoms from a fall onto one's buttock that later developed into symptomatic spondylolisthesis or a herniated disc because it depends on the amount of time between the onset of symptoms in the back and the ankle. It could mask the pain for several days. Claimant could also have woken up with soreness and stiffness in his back a few days after falling even without the ankle sprain.<sup>393</sup>

The fact that Claimant returned to work after his work injury and felt immediate sharp onset of pain in his back shooting into his left leg is consistent with hurting his back seven days earlier, being preoccupied with ankle pain, resting, returning to work, and bending and stooping, causing sharp shooting pain in his back and onto his leg.<sup>394</sup>

Claimant's credibility is raised based on the drug-seeking behavior, descriptions of different mechanisms of injury, and no mention of a fall or pain in the lower back.<sup>395</sup>

***Dr. James Chiverton testified by deposition in pertinent part that:***<sup>396</sup>

He practices general internal medicine and pain management with Axxcess Medical Clinic. He graduated from medical school in 1994, interned from 1994 to 1995 and did his residency from 1995 to 2000. He uses an integrated approach of traditional and alternative medicine. The purpose of pain management is to provide enough control for a patient with chronic pain that has lasted for more than six months. Pain interferes with a patient's way of life at home and at work. He looks for the impact of the pain and tries to reduce it.<sup>397</sup>

He first treated Claimant on 09 Aug 05. Claimant noted on the patient registration form that he took Lortab and Soma prescribed by Dr. Chambers. Claimant also signed a pain management contract - Consent for Opiate Management Therapy of Intractable Pain. The purpose of a pain management contract was to provide Claimant with the legal restrictions and obligations of using the prescribed controlled substances for treatment of pain. It basically tells a patient what their obligations are being prescribed pain medication. Upon signing the pain management contract, Claimant agreed to have periodic and random drug screens, submit to a psychiatric evaluation, refrain from alcohol, and refrain from visiting

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<sup>393</sup> EX-35, pp. 84-91.

<sup>394</sup> EX-35, pp. 91-92.

<sup>395</sup> EX-35, pp. 105-109.

<sup>396</sup> EX-41.

<sup>397</sup> EX-41, pp. 8, 11-14, 78-81.

other pain management clinics or doctors for additional prescriptions. Dr. Chiverton must make sure that his patients do not sell their pain medication or doctor shop for additional medication. If a patient does not get much relief from the pain medication, then he will look for another avenue of treatment, such as surgery.<sup>398</sup>

Claimant filled out a questionnaire prior to treating with Dr. Chiverton. He noted his pain level at 5 out of 10 with pain medication. He noted that Dr. Chambers released him on 27 Jun 05. Claimant further reported the last time he received medication was on 27 Jun 05, other than his wife's medication. Dr. Chiverton was not sure whether that meant Dr. Chambers released Claimant with medication. Since there was a report from Dr. Chambers dated 13 Jul 05 and prescriptions for Hydrocodone and Soma by Dr. Chambers filled on 13 Jul 05, Claimant was mistaken as to the date of his release. He could just be confused as to the date and year because he also wrote down the wrong date on the intake form. Claimant also told Dr. Chiverton that he was prescribed 90 pills each of the Hydrocodone and Soma, but the pharmacy records reflect he only received 60 pills of each. Dr. Chiverton considers this inaccurate information a violation of the pain management contract. However, just because Claimant received a prescription on 13 Jul 05 and on 15 Jul 05, does not mean it was inconsistent with the information he provided to Dr. Chiverton. Thirty pills for a patient with chronic pain would last about five days. If a patient filled a prescription two days later at a different pharmacy for the same medication, it is an indication of pharmacy shopping. It also makes him think about whether Claimant is forging prescriptions or lying to a doctor and saying they were stolen. Although those two prescriptions totaled 90 pills as Claimant stated he was prescribed, Dr. Chiverton testified it would be a big assumption to just assume that Dr. Chambers corrected a mistake.<sup>399</sup>

A review of the Folsie Pharmacy records also reflected that Claimant filled a prescription by Dr. Chambers for amitriptyline, used for sleep, on 10 Aug 05, one day after he treated with Dr. Chiverton. That alone would not be a violation of the pain management contract, but the inaccurate statements of discharge and lack of medication concerns Dr. Chiverton. Dr. Chiverton has not only an ethical duty, but also a legal duty to make sure he knows what type and how much medication his patients take and whether they are doctor shopping. Had he noticed an inconsistency, he would have sat Claimant down and talked to him about the importance of one person overseeing his medication to prevent Claimant from doing something illegal or hurting himself. He may have also discharged him

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<sup>398</sup> EX-41, pp. 16-21, 23, 25-27.

<sup>399</sup> EX-41, pp. 28-36, 41-46, 89-91, 100-101, 121.

from treatment with instructions for a new physician. He would have also referred Claimant to a rehabilitation program that is more integrated with onsite therapists and counselors or perhaps inpatient rehabilitation therapy. If he kept him as a patient, he would drug screen him every time he came in and Claimant would need to come in for a pill count every week.<sup>400</sup>

There are 27 days between 13 Jul 05 and 09 Aug 05. If Claimant filled both the July prescriptions he would have 90 pills to last him the 27 days. He was prescribed four pills daily. Therefore, he would have needed 108 pills to last him the 27 days and he only had 90. Claimant would have run out of medication about four days before he saw Dr. Chiverton on 09 Aug 05. A patient's reaction to running out of pain medication depends on "how much decorum you have" and how they were raised. There is no typical reaction.<sup>401</sup>

Dr. Chiverton prescribed Claimant five Lortabs daily. He believed that amount would be appropriate to assist Claimant in dealing with his pain until his follow-up appointment. He previously prescribed four pills daily, but it was not enough. He increased the amount to five pills daily to see if that helped Claimant be more functional. Had Claimant returned and told him that the five pills helped, but his pain still interfered with his life, Dr. Chiverton would have considered increasing the pills to six per day.<sup>402</sup>

On 24 Aug 05, Dr. Chiverton gave Claimant a prescription for 75 Hydrocodone and 60 Soma. He also prescribed a new medication, Mirtazapine (# 15), for depression, sleep and anxiety. It would not be good for Claimant to take both the Amitriptyline and Mirtazapine, but Dr. Chiverton did not know that Claimant was prescribed the Amitriptyline. Claimant filled a Soma prescription for 60 pills on 09 Sep 05 from Dr. Vogel. He then refilled his prescriptions on 20 Sep 05, but it was not from Dr. Chiverton. It was right after Hurricane Katrina and if Claimant had his bottle on him, some pharmacies would have given him the same amount until he was able to get in touch with his physician. It was an emergency situation and some pharmacies in Louisiana loosened restrictions to be humane.<sup>403</sup>

Claimant continued to violate his pain management contract by filling various prescriptions too close to each other. Based on the various physicians that appear on various pharmacy records, he opined that Claimant was pharmacy and doctor shopping for his medication. He was engaged in drug seeking behavior. The pain management contract Claimant signed for Dr. Chiverton limited him to filling his prescriptions at one pharmacy, which Claimant violated. Claimant never indicated he was getting medication from various doctors. It is a problem when a patient

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<sup>400</sup> EX-41, pp. 36-38, 71-73.

<sup>401</sup> EX-41, pp. 113-116.

<sup>402</sup> EX-41, pp. 123-126.

<sup>403</sup> EX-41, pp. 38-43.

does not disclose the extent of medical treatment or medications that he has received. It jeopardizes the patient's health and can be toxic. It can cause problems with the liver and hepatitis.<sup>404</sup>

Just because a patient goes to different pharmacies does not always mean they are engaging in drug seeking behavior. If it is after they receive new medication, they may be looking for the greatest discount. There are definitely patients who enter the pain management program solely for the purpose of obtaining pain medication. The best way to distinguish between drug seeking behavior and a need to control pain is to simply listen to the patient. Drug-seekers usually ask for specific medications. It also helps to have the patients come in for a pill count. At least Claimant had not rejected potential treatment options and was merely waiting for the litigation to be settled. If Claimant is addicted to his pain medication, then it is important to get him into a drug rehabilitation program and psychiatric involvement.<sup>405</sup>

He diagnosed Claimant with a displaced lumbar disc at the L4-L5 level, degenerative disc at the L5-S1 lumbar level, and spondylolysis.<sup>406</sup>

He could not opine as to whether Claimant was addicted to his pain medication because everyone is different. Soma is also addictive. The only way to determine whether Claimant is addicted to his pain medication would be to taper him off the pills. If someone takes four Lortabs and four Somas daily, signs of physiological addiction would include increased heart rate, blood pressure, and irritability. You would also see drug-seeking behavior. You look to see how disruptive the medication is versus whether it is contributive to the patient's life. If a patient has been taking these medications over a period of two years, stopping the medication could cause nausea and vomiting as well. If you take a patient's medication away and they have pain, they will get more irritable. Stockpiling medication is another warning sign that a patient is becoming addicted. He cannot blame his patients for doing it during hurricane season, but they still should not do anything illegal.<sup>407</sup>

He has never reviewed Claimant's MRI reports. Even if there is a herniation, it does not necessarily mean there is pain unless it causes a significant compromise in the foramen where it exists. It is reasonable to expect atrophy because of an L5 radiculopathy. He would not have prescribed Claimant pain medication had he thought Claimant's subjective complaints of pain were not true. Assuming Claimant has a herniated disc, spondylolysis, and pressure on the nerve causing atrophy, there is no amount of medication that Claimant could take daily to control or attempt to control his pain – it is trial and error. Patients with real pain tend to

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<sup>404</sup> EX-41, pp. 47-71, 76.

<sup>405</sup> EX-41, pp. 72-76, 125-128, 135-136.

<sup>406</sup> EX-41, p. 94.

<sup>407</sup> EX-41, pp. 94-99, 130-131.

manage their pain much more efficiently than patients who are misusing their pain medicines. It is a fallacy to suggest that a biological condition treated with an appropriate amount of medication will result in an addiction.<sup>408</sup>

## **ANALYSIS**

### **Conflicting Testimony**

There are a large number of direct contradictions in the witnesses' testimony in this case:

Claimant testified at trial that he twisted his ankle when he stepped on a four by four. His ankle started to hurt so bad that he held onto straps to not put weight onto his ankle. The load was raised while he was still holding on and he did not want to be lifted off the deck, so he let go and fell about one foot to the deck onto his tailbone. The LS-203,<sup>409</sup> describes the accident as "rigging up, unloading . . . moved off to get out of way of load on crane, tripped and hurt left ankle." The LS-203 did not mention falling to the deck floor onto his backside. In addition, Employer's Root Cause Analysis form<sup>410</sup> also described the accident as Claimant backing up onto a wooden block and twisting his ankle. However, it later stated that Claimant twisted his ankle which forced him to fall to the boat deck. The Contractor's Report of Occupational Injury or Illness<sup>411</sup> stated that Claimant only injured his ankle and there was no mention of falling to his back. Employer's Supervisor's Report of Employee Occupational Injury dated 09 Jan 03 states that Claimant stepped off of a four by four and sprained his left ankle. There is no mention of falling to his back and the witness statement from Kevin Bellow reported that Claimant merely sprained his ankle.

Claimant also testified that he did not complete the LS-203 dated 18 Mar 03, which describes the injury as "hurt ankle." Claimant contends that he cannot read or write well and he did not complete the forms. However the LS-203 mirrors Claimant's original description of the accident, which he admitted completing and contains the same misspelling. He said he did not report an injury to his back because he did not feel immediate pain in his back. However, he also testified that he did not report his back injury because he wanted to go back to work and needed the money. Claimant never submitted his no work slips to Employer. Claimant did not tell his girlfriend that he injured his back until after he returned to work on 16 Jan 03.

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<sup>408</sup> EX-41, pp. 99-108.

<sup>409</sup> CX-1.

<sup>410</sup> EX-12.

<sup>411</sup> EX-21.

Claimant additionally testified that he did not feel immediate pain in his back and that is why he did not inform the physician's assistant about falling onto his back. He claims he did not feel pain in his back until several days after his ankle injury and thought the pain was due solely to his resting from his ankle injury. However, the Worker's Compensation Accident form,<sup>412</sup> which was not dated, states that Claimant felt pain immediately after the accident in his "ankel [sic]" and back. Claimant also informed Dr. Gudan that he had pain in his back immediately after the accident. He then stated that he first felt back pain radiating into his thigh when he returned to work on 16 Jan 03.

Claimant further testified he took his medication as prescribed and did not engage in drug seeking behavior. There is evidence that Claimant sought treatment from various physicians and filled his prescriptions at different pharmacy locations. There are periods of overlapping prescriptions. In addition, Dr. Chiverton, Dr. Applebaum, and Dr. Mogan admitted that Claimant's behavior can be considered drug seeking behavior.

Claimant testified that he tried contacting Employer on several occasions, but never received a call back. He stated he tried to call Mr. Hux several times and left him a message to call back. He admitted that he never left a message with the 24-hour dispatch number.

Jackie Beard testified that he witnessed the accident and that Claimant at no time fell to his back. He testified that Claimant did not fall because he continued to hold onto the load. However, Kevin Bellow testified that he was standing next to Mr. Beard and there was no way that Mr. Beard saw the accident because both of their views were disrupted.

### **Witness Credibility**

Given the clear conflicts in the witnesses' accounts of the facts and the direct relevance of those factual disputes to the issues in this case, the credibility assessment of the witnesses is significant.

*Claimant* appeared in person. He has the most substantial personal interest in the outcome of this case.<sup>413</sup> His testimony as to the mechanism of injury was corroborated by some witnesses, but then in large part directly contradicted by other testimony and documents in the case. In court, Claimant's demeanor was unremarkable in terms of

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<sup>412</sup> EX-25.

<sup>413</sup> Although this is true in every case in which a party testifies and should not be grounds for automatically discounting credibility, it must be considered, particularly in terms of assessing inconsistent statements by that party/witness.

assessing credibility, but some of his key testimony was uncorroborated and directly contradicted by other testimony and documents in the case. He was also impeached with inconsistencies. These inconsistencies negatively affect Claimant's credibility<sup>414</sup> as to his testimony related to his back injury and the mechanism of injury.

While the possibility that Claimant may have taken more pain medication than prescribed and engaged in drug seeking behavior may impact his credibility, it does not necessarily mean he did not injure his back or is exaggerating his pain or disability. The evidence on this issue is equivocal and makes it impossible to clearly determine if Claimant abused his prescriptions. He has been prescribed pain medication for over 3 years and may have developed a tolerance to the medication. A review of the prescription records is not conclusive, given Hurricane Katrina and its impact on Claimant's ability to continue with his regular physicians. More probative is the fact that although some doctors testified that Claimant may be violating the pain contract, Dr. Mogan, who continues to treat Claimant, reviewed the prescription records and opined that Claimant was compliant with his pain management contract. He also opined that the quantities were appropriate for Claimant's condition. In any event, even if Claimant has become addicted to narcotic pain medication and engaging in drug seeking, he may still be suffering pain associated with his work injury. Therefore, the Court does not find that Claimant's prescription behavior weighs heavily in the determination of whether Claimant in fact suffered a back injury.

*Claimant's girlfriend* appeared in person. Her demeanor and manner made her appear to be credible.<sup>415</sup> However, her interests are clearly aligned with Claimant's and much of her testimony was based on what Claimant told her.

*Octave Jackson* appeared in person. He was Claimant's co-worker at the time of injury. He appeared to be candid and forthright and his testimony was corroborated by other witnesses. Mr. Jackson was a credible witness.

*Kevin Bellow* appeared in person. He was Claimant's foreman at the time of the injury. His demeanor and manner were positive and he appeared to be a credible witness.

### **Notice of Injury**

Assuming that Claimant's back condition is related to the 9 Jan 03 incident, it is a separate and discrete injury, albeit arising from the same accident. There is no suggestion in the record that the back injury was derivative of the ankle injury. Thus, Claimant was obliged under the Act to notify Employer within thirty days of the date he became aware

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<sup>414</sup> Employer relied on *Scalio v Ceres Marine Terminals*, to argue that Claimant's inconsistencies should bar him from invoking the Section 20(a) presumption. However, the claimant in *Scalio*, when confronted with the inconsistencies gave no explanation, thereby rendering his testimony unreliable and did not invoke the presumption. 40 BRBS 328 (2006). Claimant, on the other hand, gave reasonable explanations regarding the inconsistencies and the inconsistencies were not extensive.

<sup>415</sup> Claimant's girlfriend admitted that she provided him pain medication from her own prescription.

of the relationship between his back and the fall on the boat. That happened no later than 17 Jan 03, when he told his girlfriend his back hurt and related it to the offshore incident. Consequently, his deadline for informing Employer was 16 Feb 03.

However, Claimant never took any steps to notify Employer that he had injured his back.<sup>416</sup> He conceded in his testimony that he knew he was required to report any injuries, but did not do so because he needed the income and wanted to return to work. Employer's personnel manager had no idea Claimant had hurt his back until this claim was filed. The evidence clearly overcomes any presumption that notice was given.

With the failure of Claimant to provide notice, the key question is whether there is substantial evidence that Employer was prejudiced in its ability to assess the nature and extent of the alleged injury or to provide medical services. Employer's personnel manager testified that he believed the ankle injury was resolved. Had he known about the back injury, he would have gotten the health and safety manager involved. The weight of evidence provides that because of the lack of notice, Employer was deprived of the opportunity to obtain medical evaluation of and treatment for Claimant, determine the extent of Claimant's physical limitations, and provide work within those limitations.

Ultimately, the record shows that Employer had no reason to reasonably believe that Claimant had done any more than injure his ankle, return to work after it had substantially healed, and then walked off the job. Employer attempted to ask Claimant to return to work, but could not get in touch with him. Employer was clearly prejudiced in its ability to assess the degree and extent of his injury, evaluate his working capacity, and help him by his failure to notify it. Consequently his claim is barred.

### **Compensable Injury**

Even though the Court determined that Claimant's failure to provide Employer with notice of a back injury, Employer may still be liable for medical benefits. Consequently, the Court must still consider all the relevant evidence and determine whether causation has been established as to the back injury.

There is clearly sufficient evidence to invoke the Section 20(a) presumption that by way of his fall on 9 Jan 03, Claimant suffered either an original injury to his back or an aggravation of a pre-existing condition that led to his intervening and current condition.

The parties stipulated that Claimant injured his ankle at work on 09 Jan 03.

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<sup>416</sup> The evidence is in conflict as to Claimant's inability to contact Employer. Claimant says he called and left messages, Employer says it never received those calls and made calls of its own that were not returned. Given the fact that Employer had a 24 hour phone line designated to receive such calls, and the fact that Claimant could have simply gone in person to Employer's office, as he did to retain an attorney, I find his account less credible.

Claimant argues that the credible evidence establishes that his fall to the deck resulted in subsequent back problems. At the hearing, Claimant described the mechanism of injury and stated that he twisted his ankle when he stepped onto a four by four, held onto straps to prevent putting weight on his ankle, and did not want to be lifted off the deck. So he let go of the straps, fell about one foot, could not land on both feet because of his twisted ankle, and landed on his tailbone. He explains that he did not report falling because any pain in his back was masked by his ankle pain. Claimant explained the inconsistencies on his previous written statements by the fact that he cannot write or read well.

Mr. Snell, a co-worker, witnessed Claimant's accident and provided a statement that Claimant lost his step, fell, and hit the deck. He saw Claimant's foot slip out from under him. Mr. Werner also saw Claimant slip and stumble. His testimony was the most consistent with Claimant's testimony. He testified that he saw Claimant step off a pipe, slip, stumble, fall to his side and end up on the deck. Mr. Sims testified that he saw Claimant fall to his rear. Mr. Williams also testified that he witnessed Claimant fall to the deck very hard, falling to his buttocks and side.

Claimant initially thought his back problems were from lying in bed. He did not relate his back pain until after he returned to work on 16 Jan 03 and attempted to complete a day of work. He testified that he started having sharp pains in his back down to his buttocks. He denied ever having similar pains in his back prior to his work injury. Claimant's girlfriend confirmed that he did not have any problems with his back prior to his work injury. Claimant began complaining to her about back pain after he tried to return to work on 16 Jan 03. That is when he told her that he actually fell down when he injured his ankle. She testified that Claimant has a lot of back pain and is suffering.

On the other hand, there is sufficient evidence to rebut the presumption that any of Claimant's current or intervening back problems are due to his fall in January 2003.

Claimant completed several reports describing his work injury. On all five reports he described an injury to his ankle and never reported anything about falling to or injuring his back. Claimant testified that as he rested in the bunk after his injury he told his visitors only that he twisted his ankle. Although Mr. Bellow did not see the accident, he completed the accident report based on exactly what Claimant told him. The first time Claimant mentioned a back injury to anyone outside his family was when he met with an attorney. Mr. Beard testified that he did not see Claimant fall to the deck, but only saw Claimant stumble backward and that Claimant could not have fallen to the deck without him seeing it happen. Claimant was treated by Employer medical staff after his accident and only mentioned twisting his ankle. Even after Claimant returned to work on 16 Jan 03 and allegedly left due to back pain, he never reported such pain to Employer or any of

his co-workers. When Employer contacted him after his return to work, Claimant merely reported that he was “hurting” and never mentioned his back. Employer argues that the medical evidence supports a finding that Claimant’s back pain is attributable to a non-occupational condition unrelated to his employment and is not a result of a traumatic injury.

Employer argues that Claimant’s back condition is the result of a degenerative spinal condition, spondylolisthesis. Mr. Carruth testified that the injection he gave Claimant for the ankle would not have masked any back pain. Dr. Katz testified that the disc protrusion is not related to Claimant’s alleged 09 Jan 03 accident, because the disc bulge is a result of the spondylolisthesis, which was not caused by the fall. Dr. Aprill testified that Claimant’s back problems were acquired in adolescence and the accident described did not cause the spondylolisthesis. He further testified that the degree of degeneration is more advanced than what the accident would have caused. In addition, Dr. Manale opined that the spondylolisthesis and degenerative disc disease preexisted Claimant’s work accident. Dr. Puente observed that persons with spondylolisthesis and degenerative disc disease can experience disc bulging without trauma and that Claimant’s atrophy is also a direct result of the spondylolisthesis. Dr. Applebaum testified that since Claimant has complaints of pain without radiculopathy, his pain was due to his spondylolisthesis and degenerative disc disease and not a result of a traumatic injury.

Given the rebuttal of the presumption, the burden is on the Claimant to establish by the weight of the evidence that the injury was work-related.

Witnesses described Claimant falling to the deck after his work related accident. Mr. Jackson testified that Claimant broke his fall with his hands. However, Claimant never complained to him about any sort of back pain. Even though Mr. Werner generally corroborated Claimant’s description of the accident, he also testified that Claimant did not fall very hard because the sling broke some of Claimant’s fall. He also denied that the load was lifted, stating that Claimant merely tripped and fell. In addition, although Mr. Sims and Mr. Williams saw Claimant fall to the deck, Claimant only told them that he believed he sprained his ankle. Although Mr. Beard testified Claimant could not have fallen without him seeing it happen, he admitted that he would only watch for about 15 to 20 minutes at a time. Also, Mr. Bellow testified that he was standing next to Mr. Beard and that there was no way that Mr. Beard could have seen the accident.

The weight of the evidence is that the load was not lifted and Claimant did not fall down off of it. He did severely twist his ankle and grabbed the load to take weight of the effected limb and lower himself to the deck. Given the pain of an ankle sprain, the speed at which he collapsed onto the sling and deck was most likely sufficient to apply a wrenching force and torque to his back. The real question is whether that force created a new back injury or aggravated pre-existing conditions of asymptomatic spondylolisthesis and degenerative disc disease.

The evidence establishes Claimant had spondylolisthesis as a pre-existing condition. However, Claimant passed a pre-employment physical and remained asymptomatic until the fall on the boat. Regardless of the degree of force sustained in the incident on the boat, Claimant had never previously complained of back pain or had problems performing his work duties. The evidence supports a finding that Claimant started having back pain around 11 Jan 03. To find otherwise would be to totally discount Claimant's testimony and statements to health care providers. Claimant's testimony is certainly contradicted by more credible evidence in many regards. However, one reason he gave for failing to notify Employer of his back injury was that he wanted to keep working. If he subjectively had no back pain and was fabricating it, he would have been more likely to immediately tell Employer. Moreover, since his accident Claimant has needed constant and continuous medical treatment and medication for his back pain. Thus, I do find that Claimant did have some back pain following the incident on the boat.

Claimant started treating with Dr. Gudan on 06 Feb 03 for complaints of back pain. Dr. Gudan concluded that Claimant sprained his lower back on 09 Jan 03 and his condition was a result of his work injury. Claimant also treated with Dr. Flynn after the work injury and complained of back pain. On 12 Feb 03, Claimant treated with Dr. Wood, who diagnosed low back pain and lumbar myofascial strain or contusion and believed the back pain could have been a result of the trauma of the accident. Dr. Aprill admitted Claimant had a small disc protrusion that could have been caused by the fall injuring an already degenerating disc. Dr. Aprill observed that when a patient who does not have back pain prior to a fall has pain after a fall, it is more likely than not that there is a cause-and-effect relationship. In addition, since the accident Claimant has developed atrophy in his thigh and calf which is consistent with pressure on the nerve root.

Dr. Vogel opined that Claimant actually has a herniated disc and that Claimant's condition is causally related to his January 2003 accident. Dr. Hubbell noted Claimant did not have back pain and worked heavy manual labor without a problem until he injured his ankle so severely that he could not bear weight on it, and only later noticed back pain. He concluded Claimant's back pain was more likely than not the result of the fall. Dr. Chambers also attributed Claimant's back injury to the report 09 Jan 03 accident. Dr. Glorioso also opined that Claimant has herniations in his back which were present in the 2005 MRI, but not the 2003 MRI. Dr. Glorioso reasoned that the worsening of the disc could be consistent with an injury in January 2003 worsening his condition. Dr. Mogan also related Claimant's current problems with his lower back to the 2003 work injury. Although Dr. Manale opined that Claimant's back problems were pre-existing, he also concluded that they were silent prior to Claimant's work injury. Dr. Applebaum testified that the fact that Claimant returned to work on 16 Jan 03 and felt immediate pain was consistent with hurting his back several days earlier, being preoccupied with an ankle injury, resting, returning to work, bending, and stooping.

Although the medical evidence is in some conflict on the point, the temporal nexus is a significant factor as described by much of the medical testimony. While coincidence does not establish causation, it is circumstantial evidence that weighs in its favor. The weight of the credible evidence in this case shows that Claimant had a pre-existing back injury for which he had not sought treatment in the past. His back problems did not become symptomatic until after his work injury on 09 Jan 03. Claimant has met his burden and established that he more likely than not suffered an aggravation of his pre-existing back problems rather than the natural progression of his degenerative disc disease. Therefore, Claimant suffered a compensable injury to his back and is entitled to medical benefits.

## **Section 7 Entitlement to Medical Expenses**

### **Reimbursement**

Claimant testified and the evidence supports the finding that he has never asked Employer to furnish or authorize medical treatment for his back. Therefore, Claimant is only entitled to reimbursement for his medical expenses if Employer refused or neglected to provide Claimant with the requested medical treatment. Since Claimant never told Employer about his back injury, it would have been impossible for Employer to have refused to authorize medical for it, and in fact witnesses testified that Employer would have provided him treatment.

While there may have been some minor confusion about a follow-up appointment for Claimant's ankle, it did not rise to the level that Claimant could have reasonably concluded Employer was refusing to provide or authorize any treatment for his ankle. Similarly, he could not have reasonably believed that based on his ankle, Employer would refuse to provide treatment for his back. In addition, at no time was Claimant in an emergency situation where his failure to seek prior authorization could be excused.

Claimant was not entitled to procure the necessary treatment on his own initiative and is not entitled to reimbursement for past medical treatment related to his back injury.

### **Future Medical Treatment and Surgery**

Claimant seeks medical costs associated with future medical treatment and surgery for his back. Not all of the physicians who evaluated Claimant agree that Claimant is a current candidate for surgery. Dr. Greenberg referred Claimant to a neurosurgeon. In August 2003, Dr. Vogel recommended a discogram and surgery to Claimant's back after the MRI on 28 May 03 showed a large disc protrusion at L5-S1 abutting the nerve root. Claimant was given pain medication and physical therapy. Dr. Hubbell prescribed injection therapy, which Claimant has not received as of the hearing.

According to Dr. Glorioso, the 30 Jun 05 MRI revealed disc herniations. On 13 Jul 05, Dr. Chambers expressed concern about Claimant taking pain medication since 2003. Dr. Chambers opined that since Claimant has been in constant pain for so long, he needed surgery. Dr. Vogel reiterated his opinion that Claimant needs surgery on 09 Jan 06 after he noticed atrophy in Claimant's calf and thigh. He reported that Claimant needed a discogram first, to determine which levels need fusion. In March 2006, Dr. Shamsnia conducted an EMG and nerve conduction study, which revealed that the L5-S1 nerve root was impinged and causing atrophy. Dr. Manale also noticed atrophy in Claimant's leg and opined that it was caused by impingement of the L5-S1 nerve root, suggesting the need for surgery.

Dr. Puente, Employer's medical examiner, reported that Claimant's back injury required further treatment. He ordered another EMG and nerve conduction study, which revealed the same findings as Dr. Shamsnia. Although he did not recommend immediate surgery, he did admit that it was reasonable for other physicians to recommend surgery. In addition, Dr. Applebaum, another IME, admitted that impinged nerves could cause atrophy, even though he could not specifically state what was causing Claimant's atrophy. Dr. Applebaum could not rule out that the atrophy was not caused by the impinged nerve and opined that Claimant may need surgery after completion of conservative treatment.

While the independent medical examiners opined that Claimant did not currently need surgery, they could not rule out that he would not need surgery once he exhausted conservative treatment. The doctors actually admitted that surgery might be necessary to help reduce some pain and prevent further damage, but that it would not resolve Claimant's problems entirely.

The Court adopts the recommended program of conservative treatments to be followed by surgery. It finds conservative treatments (physical therapy and injection therapy) to be reasonable, necessary, and appropriate. If they do not provide satisfactory relief, as determined by Claimant's treating physician, surgery (discogram and fusion) is then reasonable, necessary, and appropriate.

### **ORDER AND DECISION**

1. Claimant suffered a compensable injury to his back as a result of his 09 Jan 03 work related accident.
2. Employer was not properly and timely notified of Claimant's work related injury to his back and was prejudiced by the lack of notice.
3. Claimant is not entitled to disability compensation.

4. Claimant failed to obtain Employer authorization before obtaining medical treatment for his back.
5. Claimant is not entitled to reimbursement of past medical bills related to Claimant's back.
6. Employer shall pay all future reasonable, appropriate, and necessary medical expenses arising from Claimant's back and ankle injury, pursuant to the provisions of Section 7 of the Act. This includes the recommended course of conservative treatment to be followed by surgery, if necessary, to Claimant's back. This does not include reimbursement of unpaid past medical bills related to Claimant's back.
7. The District Director will perform all computations to determine specific amounts based on and consistent with the findings and order herein.
8. Claimant's counsel is hereby allowed thirty (30) days from the date of service of this decision by the District Director to submit an application for attorney's fees.<sup>417</sup> A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days after receipt of such application within which to file any objections thereto. In the event Employer elects to file any objections to said application it must serve a copy on Claimant's counsel, who shall then have fifteen (15) days from service to file an answer thereto.

**So ORDERED.**

**A**

**PATRICK M. ROSENOW**  
**Administrative Law Judge**

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<sup>417</sup> Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. *Revior v. General Dynamics Corp.*, 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of Administrative law Judges provides the clearest indication of the date when informal proceedings terminate. *Miller v. Prolerized New England Co.*, 14 BRBS 811, 813 (1981), *aff'd*, 691 F.2d 45 (1st Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after **16 Jun 05**, the date this matter was referred from the District Director.